

U.S. No. 2
FORM-5-43
REV. 5-17-39
I X36871

FILED DEC 9 1944

Registration District No. 199 Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: JACKSON

(a) County JACKSON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
123 EAST 34TH STREET
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

In this community 30 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 312
(If outside city or town limits, write "RURAL")

(d) Street No. 123 EAST 34TH STREET
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ?

3. (a) MISS PRINT FULL NAME DELIA HERRICK JACOBS

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased FEB 9TH 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace SHREVEPORT LA.
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business OFFICE WORKER

12. Name THOMAS NEWMAN

13. Birthplace VIRGINIA
(City, town, or county) (State or foreign country)

14. Maiden name DELIA HERRICK

15. Birthplace VERMONT
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Louise M. Flanders

(b) Address 100 West 49th Street

17. (a) CREMATION (b) Date thereof NOV 29 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS

18. (a) Signature of funeral director D.W. Newcomer's son

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 11-29-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 26TH year 1944 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov. 23 1944 to Nov 26 1944; that I last saw her alive on Nov. 26 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to arteriosclerotic heart disease

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M.D. or other) _____

Address Kansas City Gen Hosp Date signed 11-27-44

206 Plaza Medical Bldg
1:30-5:30

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

R. C. Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address R. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.