

Registration District No. \_\_\_\_\_

149

Primary Registration District No. \_\_\_\_\_

1002

Registrar's No. 5285

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2838 Troost Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None (Specify whether)  
In this community 50 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2838 Troost Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Florence M. HOBBS.

3. (b) If veteran, name war None 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: August 26th 1873  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
71 4 0 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Time Well Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name: Dr. W.F. Hobbs.  
13. Birthplace: Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name: Alice Young  
15. Birthplace: Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Pauline Reardon  
(b) Address: 1407 West 50th, Street.

17. (a) Burial (b) Date thereof: 12/28/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Forest Hill

18. (a) Signature of funeral director: Melody-McGilley  
(b) Address: K. C. Mo.

19. (a) 12-27-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 26th  
year 1944 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from Dec 1  
1944 to Dec 26 1944  
that I last saw her alive on Dec 24 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Mild Bronchopneumonia  
Due to: Diabetic Mellitus

Due to: \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 61  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

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: Paula Johnson (M. D. or other) MD  
Address: 1103 Eastwood Date signed: 12-27-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

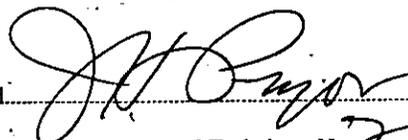
Dr. Carl Jackson  
1103 E. Armour Blvd.

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**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 .....  
Licensed Embalmer No. 2997  
P. O. Address KC

**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.**