

FILED FEB 6 1945
Registration District No. **199**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (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:
4011 E. 39th Street,
(If not in hospital or institution, write street number or location)
no.
 (d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days)
 In this community: **46 years,** 1 (Specify whether

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson,** **48**
 (c) City or town **Kansas City,** **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. **4011 E. 39th St.,** **8**
(If rural, give location)
 (e) Citizen of foreign country? **no.** (Yes or No)
 If yes, name country _____ **x 0**

3. (a) PRINT FULL NAME Mrs. Margaret B. Gardner
 3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **16th**
 year **1945** hour _____ minute **P.** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **H. C. Gardner** 6. (c) Age of husband or wife if alive **75** years
 7. Birth date of deceased **January 24 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **day of death** to _____ 19**45**
 that I last saw him alive on **Jan 16** 19**45**
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

8. AGE: Years **74** Months **11** Days **28** **22** hr. _____ min. _____
 If less than one day _____

Due to **Cardiac thrombosis**
 Due to **Chronic heart failure and atherosclerosis**
 Other conditions **94a**
(Include pregnancy within 3 months of death)

9. Birthplace **Kansas** (City, town, or county) (State or foreign country)
 10. Usual occupation **at home,**

Major findings: Of operations _____
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

11. Industry or business **x**
 12. Name **William R. Brown,**
 13. Birthplace **unknown,** **9**
(City, town, or county) (State or foreign country)
 14. Maiden name **unknown,**
 15. Birthplace **unknown,** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **H. C. Gardner,**
 (b) Address **4011 E. 39th St., K. C., Mo.**
 17. (a) **Burial** (b) Date thereof **1-19-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Lawrence, Kansas.**

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 _____

18. (a) Signature of funeral director **Stine & McClure,**
 (b) Address **3235 Gillham Plaza, K. C., Mo.**
 19. (a) **1-17-45** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

23. Signature **James J. Ferguson** (M. D. certifying)
 Address **410 Bryant Blvd** Date signed **1/17/45**

Dr. James T. Ferguson, Bryant Bldg.,
Gr. 1330 Li 8100

2.P.M.

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 E. M. Plank.....

Licensed Embalmer No. 1848.....

P. O. Address R. C. 1720.....

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.