

FILED FEB 8 1945

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 240

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: 3922 Waddell
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 67 years /
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48
(c) City or town Kansas City 5
(If outside city or town limits, write "RURAL") 6
(d) Street No. 3922 Waddell
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Mrs Exilda Hahn

3. (b) If veteran, name war 700 3. (c) Social Security No. 700

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 88 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Montreal Canada
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name Revaist

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

14. Maiden name Margaret Etue

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

16. (a) Informant Miss Lena Hahn

(b) Address 3922 Waddell

17. (a) Burial (b) Date thereof -1-17-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

18. (a) Signature of funeral director Thos. E. Quirk

(b) Address 4316 Troost

19. (a) 1-16-45 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15
year 45 hour 5 minute 25 A. M.

21. I hereby certify that I attended the deceased from Nov. 20
1944, to 1-8 1945

that I last saw her alive on 1-7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Uremia
Capillary Necrosis
Hypertension
Dysuria
6-8
4-6
2 yrs

Due to _____

Due to Chronic nephritis

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

Major findings: Of operations 13/15

Of autopsy None

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) (c) Means of injury _____

23. Signature Bertha E. E. ... (M. D. or D. O.)
Address St. Mary's Hosp Date signed 1-16-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. Ewing

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 *Thomas E. Quirk*

Licensed Embalmer No. *3775*

P. O. Address *12 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.