

Registration District No. 149 Primary Registration District No. 1002

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 ST JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 1 DAY (Specify whether years, months or days)
In this community 50 YEARS (Specify whether years, months or days)

3. (a) PRINT FULL NAME ADAMS, MATTIE W. HENDRIX
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 MARRIED
6. (b) Name of husband or wife WILGARD E ADAMS
6. (c) Age of husband & wife if alive unk years
7. Birth date of deceased OCT 23 1876 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	68	2	7	hr. min.

9. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
10. Usual occupation HOUSEWIFE

11. Industry or business
12. Name JOHN C. HENDRIX
13. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
14. Maiden name AGNES ANN RENNICK
15. Birthplace KENTUCKY (City, town, or county) (State or foreign country)

16. (a) Informant William E. Adams
(b) Address 2141. Kansas City, MO
17. (a) BURIAL (b) Date thereof JAN 2 1945 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. MORIAH CEM.

18. (a) Signature of funeral director W. H. Newcomer's Sons
(b) Address 1401 BRUSH @ CREEK BLDG.
19. (a) 12-31-44 (b) D. E. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY RURAL R 1
(If outside city or town limits, write "RURAL")
(d) Street No. 103 1/2 CENTRAL (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month DEC day 30TH
year 1944 hour 9 minute 05 A. M.
21. I hereby certify that I attended the deceased from DEC 26 1944
to DEC 30 1944
that I last saw her alive on DEC 30 1944
and that death occurred on the date and hour stated above.

Immediate cause of death MYOCARDIAL FAILURE
Duration 24 HRS
Due to DIABETES MELLITUS 10 YRS.

Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 61
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 J. L. Hoffman (M. D. or other)
Address MAINTON MO Date signed

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

MOTHER FATHER

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. 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.