

FILED FEB 6 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 370

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:
SELLERIE HOTEL 214 EAST ARMOUR BLVD.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-DAYS (Specify whether years, months or days)

3. (a) PRINT FULL NAME KIM MANN MUMMA

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 OCTOBER-7-1944
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
	3	16	hr. min.

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

10. Usual occupation INFANT

11. Industry or business _____

12. Name MAJOR ROBERT M. MUMMA

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

14. Maiden name BARBARA L. M. KIMMIE

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

16. (a) Informant MAJOR ROBERT M. MUMMA

(b) Address LEAVENWORTH KANSAS

17. (a) REMOVAL (b) Date thereof JAN-23-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HARRISBURG, PENNSYLVANIA

18. (a) Signature of funeral director W. H. Newcomer, Jr.

(b) Address 1401 BIRCH CREEK BLYD.

19. (a) 1-23-45 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State PENNSYLVANIA (b) County DAUPHIN

(c) City or town HARRISBURG
(If outside city or town limits, write "RURAL")

(d) Street No. 1729-NORTH FRONT STREET
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 23 year 1945 hour 11 minute 00A. M.

21. I hereby certify that I attended the deceased from January 21, 1945 to January 23, 1945
that I last saw him alive on January 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Enlarged Thyroid Gland

Due to unknown

Due to _____

Other conditions 64
(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 Harold A. Fallick (M. D. or other) _____
Address 1103 Grand Ave Date signed 1/23/45

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

803

1-6
1132 Professional Body

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..... *Edward Hothey*
Licensed Embalmer No. *1767*
P. O. Address..... *Kansas City*

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.