

**FILED FEB 14 1945**  
 Registration District No. **149**

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:  
**Gen. Hos p. #2.**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **1-19-45-1-26-45**  
(Specify whether  
 In this community **26 yr.**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **1232 Tracy**  
(If rural, give location)  
 (e) Citizen of foreign country? **no** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **EMMA WIGGINS**  
 3. (b) If veteran, name war **None**  
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **January** day **26**  
 year **1945** hour **1:35** minute **0.** M.  
 21. I hereby certify that I attended the deceased from  
**January 19**, 19**45**, to **January 26**, 19**45**  
 that I last saw her alive on **January 26**, 19**45**  
 and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **Negro**  
 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **Sam Wiggins**  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **December 31 1877**  
(Month) (Day) (Year)

Immediate cause of death **Acute Congestive heart failure**  
 Duration \_\_\_\_\_

8. AGE: Years **67** Months **0** Days **28**  
 If less than one day **2.5** hr. \_\_\_\_\_ min.

Due to **Hypertensive type heart disease**

9. Birthplace **Kaufman County Texas**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

10. Usual occupation **At Home**

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

11. Industry or business \_\_\_\_\_

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

MOTHER FATHER { 12. Name **Isaac Warren**  
 13. Birthplace **Texas**  
(City, town, or county) (State or foreign country)

Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER { 14. Maiden name **Elsie Ellard**  
 15. Birthplace **Texas**  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant **Record Clk.**

(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)  
 Means of injury \_\_\_\_\_

17. (a) **removal** (b) Date thereof **1/30/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Terrell, Texas**

18. (a) Signature of funeral director **Hatkins Bros**  
 (b) Address **1729 Lydia**

23. Signature \_\_\_\_\_  
(M. D. or other)  
 Address **Gen. Hoig # 2-600 E 22** Date signed **1-30-45**

19. (a) **1-30-45** (b) **D. E. Brown**  
(Date received local registrar) (Registrar's signature)

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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.....

*J. Jerome Manlove*

Licensed Embalmer No.....

*3994*

P. O. Address.....

*2503 Highland*

**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.**