

FILED FEB 17 1945
49

Registration District No. _____

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:
3242 Norledge Court Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 yrs**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Florence L. Paynter**
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, widow **Widow**
6. (b) Name of husband or wife **Perry C. Paynter**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **3 20 1861**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	10	18	hr. _____ min.

9. Birthplace **New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Haskins**

15. Birthplace **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. C.A. Paynter**

(b) Address **3803 Terrace**

17. (a) Removal **(b) Date thereof** **2-9-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Superior Nebraska**

18. (a) Signature of funeral director **Mrs. C.L. Forster**

(b) Address **Kansas City, Missouri**

19. (a) 2-8-45 **(b) W. E. Brown**
(Date received local registrar) (Registrar's signature)

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. **3242 Norledge**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **8th.**
year **1945** hour **9** minute **A.** M.

21. I hereby certify that I attended the deceased from **July**
1 **er** **1944** **to** **February 8** **1945**
February 6 **1945**
that I last saw h_____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
cerebral hemorrhage.

Due to **paroxysmal hypertension**
from adrenal tumor (N.M.O.)

Due to _____

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

Major findings: _____
Of operations _____
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)
Means of injury _____

23. Signature **Joseph Deasley**
Address **1924 East 31st St. KCMo** Date signed **2/8**

Duration _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

Dr. Stephen Beasley 1924 East 31st. Street

Before noon

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 Theron R. Redman

Licensed Embalmer No. 2137

P. O. Address A. C. No

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.