

FILED MAR 24 1945

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:
6833 Locust Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 Months**
(Specify whether in this community **9 Months** 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. **6833 Locust Street**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Mrs. Edith D. Collins**

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 **DeArmond Collins** 6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **February 10 1875**
(Month) (Day) (Year)

8. AGE: Years **70** Months **0** Days **26**
If less than one day hr. min.

9. Birthplace **Burden Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

12. Name **James H. Smith**

13. Birthplace **Delaware Co. Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Eunice Faust**

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

16. (a) Informant **DeArmond Collins**

(b) Address **Wichita, Kansas**

17. (a) **Removal** (b) Date thereof **3rd 9th 45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wichita, Kansas**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Mo.**

19. (a) **3-8-45** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **6th** year **1945** minute **30 P** M.

21. I hereby certify that I **attended** the deceased from **March 11** 19**45** to **March 11** 19**45**
that I last saw **her** alive on **March 11** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Primary Bronchogenic carcinoma of left lung with metastasis to the right lung.**
Due to **As Above**
Other conditions **47.8**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **As Above**
Of autopsy **As Above**

Duration

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?
(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 **H. B. Albright** (M.D. operator)
Address **Kansas City, Mo.** Date signed **3-7-45**

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

8519

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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, 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.