

FILED MAY 15 1945
149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1987

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: Sittle Sisters of Poor
5331 Highland
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 mo
(Specify whether years, months or days)

In this community 32 yrs
(Specify whether 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. 5331 Highland
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Adelia Kane

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, Widowed

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 12 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER

12. Name Gustave Chamberland

13. Birthplace No record
(City, town, or county) (State or foreign country)

14. Maiden name Anna Barnes

15. Birthplace No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Sittle Sisters of the Poor

(b) Address 5331 Highland

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 5/7/45
(Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director David W. John Co

(b) Address 20 W Linwood

19. (a) 5-5-45
(Date received local registrar)

(b) Seraldine Holmes
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day May
year 1945 hour 11:08 minute P M.

21. I hereby certify that I attended the deceased from April 1
1945 to 1945

that I last saw her alive on 5-1
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Cardiac Degeneration

Due to Arteriosclerosis

Other conditions 95C²
(Include pregnancy within 3 months of death)

Major findings: me

Of operations me

Of autopsy me

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 John T. Johnson (M. D. or other) MD

Address 11879 Green Ave. N. P. Mo Date signed 5-4-45

Duration

3 days

6 hr

year

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Charles M. Jaurk

Licensed Embalmer No. 3774

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.