

FILED APR 24 1945
Registration District No. 150

Primary Registration District No. 5572

State File No. _____
Registrar's No. 38

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Emg. Hospital
(If not in hospital or institution, write street number or location)

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

In this community 52 yrs

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. 1927 Broadway
(If rural, give location)

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

3. (a) PRINT FULL NAME HAMMOND, ANN Lou rde

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Wh.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas Hammond 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased October 18 1879
(Month) (Day) (Year)

8. AGE: Years 69 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Michael Conley

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

14. Maiden name Margaret Byrne

15. Birthplace Madison Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas Hammond

(b) Address 1927 Broadway

17. (a) Burial (b) Date thereof 3-22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Church

18. (a) Signature of funeral director J. F. O'Donnell

(b) Address 3156 Grandview

19. (a) Mar. 20, 1945 (b) F. M. Schick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th
year 1945 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3-11-45
to 3-18-45, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia Duration 7 days

Due to Similarity with Senile psychosis

Due to Malnutrition

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

Major findings: Of operations _____

Of autopsy 107

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

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 C

Signature J. F. O'Donnell (M. D. or other) _____

Address 29 Campbell Date signed 3-20-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 P. H. Rowe
Licensed Embalmer No. 2347
P. O. Address K C 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.