

FILED JUN 1 1945

Registration District No.

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: Research Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 21 days  
(Specify whether  
In this community 35 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3652 Campbell  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13th  
year 1945 hour 7 minute 15 a.m.  
21. I hereby certify that I attended the deceased from April 20  
1945 to May 13 1945  
that I last saw her alive on May 10 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 23 days  
Due to General arteriosclerosis with hypertension  
Due to

Other conditions (Include pregnancy within 3 months of death)  
Major findings: 830  
Of operations  
Of autopsy  
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? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
While at work? (e) Means of injury  
23. Signature Herbert White (M. D. or other)  
Address 1103 Grand Ave Date signed 5/14/45

3. (a) PRINT FULL NAME Mrs. Matilda M. Applegate

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Jan 15th 1865  
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 28 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business

MOTHER FATHER { 12. Name William McIntyre  
13. Birthplace Scotland (City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Scotland (City, town, or county) (State or foreign country)

16. (a) Informant Richard R. Applegate  
(b) Address 2721 Indiana

17. (a) Burial (b) Date thereof 5-15-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt Washington Cemetery

18. (a) Signature of funeral director Melody McGilley-Eylar  
(b) Address Kansas City Missouri

19. (a) 5-15-45 (b) Sheldine Holmes  
(Date received local registrar) (Registrar's signature)

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

HC  
3  
8

Kansas City Mo.

Dr H.S. Valentine  
Prof Bg VI 1938

1124

**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 Glenn E. Heck

Licensed Embalmer No. 4063

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.**