

FILED MAY 26 1945
 199

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:
4226 St. John Ave
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 33 years
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. 4226 St. John Ave.
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MRS. MARGARET UNDERWOOD
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 7th day May
 year 1945 hour 4:15 minute P M.

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife William Underwood
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 31 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 6 1944 to May 7 1945
 that I last saw her alive on May 7 1945
 and that death occurred on the date and hour stated above.

8. AGE: Years 75-78 Months 11 Days 6
 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage
 Duration 1 hour

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

Due to Hypertension Chronic Nephritis
 Duration 1 year
 Due to _____
 Duration _____

10. Usual occupation Housewife

Other conditions Blindness
(Includes pregnancy within 3 months of death)
 Duration 5 months

MOTHER FATHER
 11. Industry or business _____
 12. Name John Wall
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Catherine Rogers
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Harry W Underwood
 (b) Address 4226 St John Ave
 17. (a) Removal
(Burial, cremation, or removal) (b) Date thereof 5/9/45
(Month) (Day) (Year)
 (c) Place: burial or cremation Leavenworth, Kansas

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) (c) Means of injury _____

18. (a) Signature of funeral director Quirk & Tobin Co
 (b) Address 20 W Linwood--K. C. Mo.
 19. (a) 5-9-45
(Date received local registrar) (b) Seraldine Holmes
(Registrar's signature)

23. Signature CUW (M. D. or other) 448
 Address 103 N. Elmwood Date signed 5/9/45

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 Quirk*

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.