

**FILED** AUG 4 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: General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 days  
(Specify whether years, months or days)

In this community 20 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. 2425 College  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Elizabeth Cook

3. (b) If veteran, name war m

3. (c) Social Security No. none

4. Sex Female 5. Color or race w

6. (a) Single, widowed, married, divorced Wed 21

6. (b) Name of husband or wife Charles Cook 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 27 1873  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 25  
year 1945 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from July 13 1945 to July 25 1945  
that I last saw her alive on July 25 1945  
and that death occurred on the date and hour stated above.

**8. AGE:**

Years	Months	Days	If less than one day
<u>72</u>	<u>1</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death metastatic schirrous carcinoma of breast

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 50

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Wm Hutchison

13. Birthplace Ohio (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Leah H Harrington

15. Birthplace ms (City, town, or county) \_\_\_\_\_ (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Perry Pierce

(b) Address Brookside

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 45  
(Month) (Day) (Year)

(c) Place: burial or cremation Brookside Cem

18. (a) Signature of funeral director Chas. C. Porter

(b) Address 918 Broadway

19. (a) 7-26-45 (Date received local registrar) (b) Geraldine Holme (Registrar's signature)

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 Clark W Seely MD (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. General Hospital Date signed \_\_\_\_\_

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..... *C. H. Wise* .....

Licensed Embalmer No..... *2570* .....

P. O. Address..... *100* .....

**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.