

Registration District No. **449** 1945

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:
ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4-DAYS**
(Specify whether years, months or days) **67 YEARS**

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. **102-NORTH MERSINGTON AVENUE**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MRS. EMMA PERRY HEITMAN**

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 **MARRIED**
6. (b) Name of husband or wife **MR. NUMA F. HEITMAN, SR.** 6. (c) Age of husband or wife if alive **84** years
7. Birth date of deceased **JANUARY-4-1871**
(Month) (Day) (Year)

8. AGE: Years **74** Months **6** Days **17** If less than one day hr. min.

9. Birthplace **WATSON'S MILL MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

12. Name **JOHN C. COLEMAN**

13. Birthplace **UNKNOWN KENTUCKY**
(City, town, or county) (State or foreign country)

14. Maiden name **EMILY CRAIG**

15. Birthplace **unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. NUMA F. HEITMAN, SR.**

(b) Address **102-NORTH MERSINGTON AVE**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **JULY-23-1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **FOREST HILL CEMETERY**

18. (a) Signature of funeral director **W.H. Newcome's Sons**

(b) Address **1401-BRUSH CREEK BLVD**

19. (a) **7-23-45** (Date received local registrar) (b) **Sheldine Holmes** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **21ST** year **1945** hour **11 a** minute _____ M.

21. I hereby certify that I attended the deceased from **July 1-45** to **July 21**, 19**45**.
that I last saw her alive on **July 21**, 19**45**, and that death occurred on the date and hour stated above.

Immediate cause of death **Fractured hip** Duration **2 days**

Due to **Myocardial Regeneration** 2 yr

Due to **Refractive** 2 yr

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

Major findings: **1864-5**
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) **Fractured hip**

(b) Date of occurrence **July 19 - 1945**

(c) Where did injury occur? **St. Clair** (City or town) **Jack. Mo.** (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**

While at work? **Yes** (Specify type of place) (e) Means of injury **fall**

23. Signature **R. L. St. Clair** (M. D. or other)

Address **5242 Maple** Date signed **7/21-45**

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

18
3
8

5247 A. John
P. 5

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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.