

**FILED** AUG 4 1945  
Registration District No. 1802

Primary Registration District No. 1802

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 2 Months  
(Specify whether years, months or days)  
In this community 21 years

3. (a) PRINT FULL NAME Alta Hutchinson

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 Harry Hutchinson 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Sept- 19th, 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>10</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation Housewife

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

12. Name Frank Danforth

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

14. Maiden name Alta Sturdevant

15. Birthplace N. Y. City  
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Hutchinson

(b) Address 3019 East 19th, St.

17. (a) Burial (b) Date thereof 7/26th 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St.

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

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. 3019 E. 19th  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1945 hour 6 minute 00 A. M.

21. I hereby certify that I attended the deceased from May 21, 1945 to July 23, 1945  
that I last saw her alive on July 23, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death  
intestinal obstruction due to mucoid carcinoma of sigmoid

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

Due to 4/6 2

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations see above  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signatures Clark Seely M.D. (M.D. or other)  
Med. Dr. K. C. General Hospital  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

Duration

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 *John B. Pope*  
Licensed Embalmer No. *2955*  
P. O. Address *18 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.**