

Registration District No. 149

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" add name of township)  
 (c) Name of hospital or institution: 316 So. ELMWOOD /  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution -- (Specify whether  
 In this community 25 Years years, months or days)

**3. (a) PRINT FULL NAME** MRS MARY JAMES  
 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 WIDOWED  
 6. (b) Name of husband or wife JAMES E. JAMES 6. (c) Age of husband or wife if alive -- years  
 7. Birth date of deceased MARCH 19 1860  
(Month) (Day) (Year)

**8. AGE:** Years 85 Months 34 Days 26 If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business At Home

**MOTHER FATHER** 12. Name JOHN ANDERSON

13. Birthplace VALDERS NORWAY  
(City, town, or county) (State or foreign country)

14. Maiden name MARY ANDERSON

15. Birthplace Unknown Norway  
(City, town, or county) (State or foreign country)

16. (a) Informant FLORENCE M. JAMES

(b) Address 316 So. ELMWOOD

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

(c) Place: burial of cremation Green Lawn Cemetery

18. (a) Signature of funeral director D. W. Newcomer Sen

(b) Address 1401 Brush Creek Blvd.

19. (a) 7-16-45 (b) Geraldine 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. 316 So. ELMWOOD  
(If rural, give location)  
 (e) Citizen of foreign country? Yes (Yes or No)  
 If yes, name country NORWAY

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JULY day 15  
 year 1945 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from June 24  
 1945, to July 15 1945

that I last saw her alive on July 13 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Thrombosis of cerebral arteries Duration 6 days

Due to Arteriosclerosis 1 year

Due to ---

Other conditions 94 W  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none **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? ---

While at work? --- (Specify type of place) (e) Means of injury ---

23. Signature [Signature] (M. D. or other) ---  
 Address 103 N. Elmwood Date signed 7-16-45

1:30-5  
ADDRESS

**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 Keith Collier

Licensed Embalmer No. 3632

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.