

S. No. 2
FORM-5-43
REV. 5-17-39
I X36871

26445

State File No. _____

FILED SEP 10 1945

Primary Registration District No. 1202

Registrar's No. 3597

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23-DAYS
(Specify whether years, months or days)

In this community 20 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 40

(c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")

(d) Street No. 514 EAST-9TH STREET
(If rural, give location)

(e) Citizen of foreign country? UNKNOWN (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME M. Edyth Harwood

3. (b) If veteran, name war No

3. (c) Social Security No. 495-243159

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MR. JOY I. HARWOOD

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased UNKNOWN
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>ABOUT 59</u>	<u>?</u>	<u>?</u>	hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name WILLIAM S. BRIGGS

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

14. Maiden name UNKNOWN

15. Birthplace _____ (City, town, or county) UNKNOWN (State or foreign country)

16. (a) Informant MRS. ALICE OWENS

(b) Address 4425 HARRISON STREET

17. (a) CREMATION (b) Date thereof Aug-29-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS

18. (a) Signature of funeral director D.W. Newcomer's Sons

(b) Address 1401-BROOK CREEK BLDG.

19. (a) 8-29-45 (b) Yvonne Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27 year 1945 hour 1 minute A M.

21. I hereby certify that I attended the deceased from August 3, 19 45 to August 27, 19 45

that I last saw h...er alive on August 27, 19 45 and that death occurred on the date and hour stated above.

Immediate cause of death _____
cardiac decompensation

Due to _____

Due to _____

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

95C²

Major findings:
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) _____

(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? _____

(Specify type of place)

While at work _____ (c) Means of injury _____

23. Signature Clark W. July (M.D. or other) _____

Address Med. Dir. K.C. General Hospital

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..... *R. C. Moore*

Licensed Embalmer No. *4043*

P. O. Address..... *R. C. Moore*

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.