

SEP 6 1945
 Registration District No. _____

Primary Registration District No. 4134

Registrar's No. 68

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

1. PLACE OF DEATH:
 (a) County Clay
 (b) City or town Smithville Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Smithville Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 130 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs MARY A NUTTER.
 3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race Wht 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Feb 4 1860
(Month) (Day) (Year)

8. AGE: Years 85 Months 6 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation H W

11. Industry or business _____

12. Name Henry F Deister

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

14. Maiden name: Margaret Hansen

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

16. (a) Informant Mrs Margaret Lynch

(b) Address No Kansas City # 4

17. (a) Burial (b) Date thereof 8-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery

18. (a) Signature of funeral director Morton Federal Home

(b) Address No. 10th Kansas City, Mo

19. (a) Aug 21 1945 (b) Beulah Kitchan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Clay 24
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. #1 Beckland
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19
 year 1945 hour 1:35 minute 0 P. M.

21. I hereby certify that I attended the deceased from April 10 1945 to Aug 19 1945
 that I last saw her alive on Aug 19 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized Art. Sclerosis
 Due to _____
 Due to _____

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

Major findings: _____
 Of operations _____
 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) Means of injury _____
 23. Signature EB Hoffa (M. D. or other) _____
 Address Smithville Mo Date signed 8-20-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1411

RECEIVED

District Health Officer No. 8,

Serial File Number

Date Filed 9-25-45

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 S. Weston
Licensed Embalmer No. 4349
P. O. Address North Kansas City

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.