

Registration District No. **149** Primary Registration District No. **1802**

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" and name of township)
 (c) Name of hospital or institution: 704 East 6th St
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 54 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson
 (c) City or town Kansas city
 (If outside city or town limits, write "RURAL")
 (d) Street No. 704 East 6th St
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME BERTHA SCOTT
 3. (b) If veteran, name war no 3. (c) Social Security No. None
 4. SEX FEMALE 5. Color or race W990
 6. (a) Single, widowed, married, divorced WIDOW
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased MAY 9 1891
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 8 day 31 year 1945 hour 7:24 PM minute _____ M.
 21. I hereby certify that I attended the deceased from Aug 18th 1945 to Aug 31st 1945
 that I last saw her alive on Aug 31st 1945 and that death occurred on the date and hour stated above.
 Immediate cause of death Cerebral Hemorrhage Duration _____

8. AGE: Years 54 Months 3 Days 22 If less than one day _____ hr. _____ min.

Due to Hypertension
 Due to Ultimate Deg. Regeneration
 Other conditions _____
 (Include pregnancy within 3 months of death)

9. Birthplace RICH HILL MO (City, town, or county) (State or foreign country)
 10. Usual occupation Domestic
 11. Industry or business home work
 12. Name Frank Oliver
 13. Birthplace Mo. Missouri (City, town, or county) (State or foreign country)
 14. Maiden name Anna Oliver
 15. Birthplace Missouri (City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings: none
 Of operations _____
 Of autopsy none 92
 Underline the cause to which death should be charged statistically.

16. (a) Informant Louise Johnson
 (b) Address 704 East 6th St
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 1945 (Month) (Day) (Year)
 (c) Place: burial or cremation Highland Care
 18. (a) Signature of funeral director W B Moore
 (b) Address 1820 E 18th St
 19. (a) 9-4-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

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 5
 23. Signature J D Juggenheim (M. D. or other) Address 222 E 18 Date signed 9/4/45

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

H B Moore

Licensed Embalmer No. 2410

P. O. Address 1870 East 18th St

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.