

No. 2
1-5-43
5-17-39
1 X36671

FILED NOV 7 1945
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 County

(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 #2 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-23-45-10-19-45
years, months or days (Specify whether)

In this community: 10-19-45 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1001 Park Ave. 8
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mary Louise Richmond

3. (b) If veteran, name war no

3. (c) Social Security No. 710

4. Sex Female 3

5. Color or race Negro

6. (a) Single, widowed, married, divorced Wid. 2

6. (b) Name of husband or wife Bud Richmond

6. (c) Age of husband or wife if alive Dec. 18 yrs

7. Birth date of deceased Nov 12, 1858
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 7 If less than one day hr. min.

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

10. Usual occupation unemployed

11. Industry or business _____

12. Name John Pace Hayes

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

14. Maiden name anna

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 10-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highlands

18. (a) Signature of funeral director Adkins Bros.

(b) Address 2000 E. 12th R.C. 7th

19. (a) 10-23-45 (b) Genevieve Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19
year 1945 hour 10 minute 25 PM.

21. I hereby certify that I attended the deceased from 8-23-45
10-19-45 19... to 19...
that I last saw her alive on 10-19-45 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia
Bronchial

Due to Senile Psychosis

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 J. Turner (M. D. or other)

Address Gen. Hosp. #2 Date signed _____

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 A. T. Moore

Licensed Embalmer No. 948

P. O. Address.....

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.