

FILED NOV 26 1945 STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 4553

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: ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY
(Specify whether
In this community 27 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY "Rural" 0
(If outside city or town limits, write "RURAL")
(d) Street No. 11317 East 39th St. Jarr. 0
(If rural, give location) R-#2.1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. SARAH JANE HENLEY

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased AUGUST 23 1868
(Month) (Day) (Year)

8. AGE: Years 77 Months 2 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace CHRISTIAN Co. MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business AT HOME

12. Name WILLIAM PARK

13. Birthplace UNKNOWN TENN. 1
(City, town, or county) (State or foreign country)

14. Maiden name SARAH WIGGINS

15. Birthplace CHRISTIAN Co. MO 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Carl J. Wt

(b) Address 11317 East 39th St. Jarr.

17. (a) REMOVAL (b) Date thereof NOV 4 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLARK, MO.

18. (a) Signature of funeral director D. M. Tucumanow

(b) Address 1401 Brush Creek Blvd.

19. (a) 11-4-45 (b) St. Pauline Holmes
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 3
year 1945 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 11-2-45
to _____, 19____, to _____, 19____;
that I last saw him alive on 11-3-45
and that death occurred on the date and hour stated above.

Immediate cause of death Moldine Cerebral Hemorrhage Duration 24 hrs

Due to _____

Due to _____

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

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? _____

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

23. Signature [Signature] (M. D. or other)
Address [Address] Date signed 11-4-45

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

MOTHER, FATHER

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

Emile M. Calhoun

Licensed Embalmer No. *3506*

P. O. Address *K C 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.