

S. No. 2.
DM-5-43
v. 5-17-39
I X36671

FILED JAN 31 1946
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
 (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 No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 mo. 12 days
(Specify whether years, months or days)

In this community 10 yrs
(Specify whether years, months or days)
3. (a) PRINT FULL NAME LENA Eva Lena Fletcher
 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 Widow
 6. (b) Name of husband or wife W = Fletcher
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased March - 28 - 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>9</u>	<u>17</u>	hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER, FATHER
 12. Name John Hill
 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Mattie
 15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ruth Green

(b) Address 8118 Olive

17. (a) Burial (b) Date thereof Jan 19 - 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation not known

18. (a) Signature of funeral director Mrs. C.R. Foster

(b) Address 918 Broadway

19. (a) 1-17-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 623 Euclid
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15
 year 1946 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from
Dec. 3, 1945, to Jan. 15, 1946
 that I last saw her alive on Jan. 15, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
 Due to Fracture left femur

Due to _____
 Other conditions 1868-5
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy None

Duration _____
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) Accident
 (b) Date of occurrence 12-3-45
 (c) Where did injury occur? K. C. Jackson, Mo.
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? No (Specify type of place) _____
 (c) Means of injury Fall in

23. Signature Clark W. Sabin
 Address Med. Dir. Gen'l Hosp. Date signed 1-26-46

Dr. C. ...

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..... *Joe B. Yoder*

Licensed Embalmer No. *4173*

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.