

Registration District No. 149

Primary Registration District No. 1002

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 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 hrs.
(Specify whether years, months or days)
 In this community unknown

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. 4312 E. 16 St. **8**
(If rural, give location)
 (e) Citizen of foreign country? no **0** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Marie Wiley
 3. (b) If veteran, name war no 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 30
 year 1946 hour 12 midnight minute _____ M.
 21. I hereby certify that I attended the deceased from 4-30 1946 to 4-30 1946
 that I last saw her alive on 4-30 1946
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced wid'ed
 6. (b) Name of husband or wife John M. Wiley 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 24 1864
(Month) (Day) (Year)

Immediate cause of death Fulmonary edema-Cardiac hypertrophy with coronary sclerosis and chronic glomerulonephritis

8. AGE: Years 82 Months 3 Days 16 If less than one day _____ hr. _____ min.

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

9. Birthplace Ohio _____
(City, town, or county) (State or foreign country)
 10. Usual occupation Housekeeper

Major findings: Of operations _____
 Of autopsy See above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name E. Tyler
 13. Birthplace Don't know 9 _____
(City, town, or county) (State or foreign country)
 14. Maiden name Don't know
 15. Birthplace Don't know 11 _____
(City, town, or county) (State or foreign country)

16. (a) Informant Robert P. Miller
 (b) Address 4312 E. 16th St. Mo.
 17. (a) Removal Removal (b) Date thereof 4-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Excelsior Springs Mo.

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 Wm W. Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 5-1-46

18. (a) Signature of funeral director Mrs C. H. Foster
 (b) Address 918 Broadway St. Mo.
 19. (a) 5-2-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

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

13436

Rev. Collins

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..... *Cordant Minor*

Licensed Embalmer No. *3414*

P. O. Address *918 Brooklyn*

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.