

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

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

**FILED** MAY 27 1946

Registration District No.                      Primary Registration District No. 1002 Registrar's No.                     

**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. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 30 yrs.

**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. 815 Brooklyn  
(If rural, give location)

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

If yes, name country                     

3. (a) PRINT FULL NAME Hazel Hubbard

3. (b) If veteran, name war no 3. (c) Social Security No. 407-05-2403

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Oscar Hubbard 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased February 20, 1901  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	45	2	23	hr. min.

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

10. Usual occupation Housemaid

11. Industry or business                     

12. Name Matthew Matthews

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

14. Maiden name Don't know

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

16. (a) Informant Medical Records Librarian

(b) Address General Hospital No. 2

17. (a) Removed (b) Date thereof May 17, 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Mo

18. (a) Signature of funeral director Walter Appleton Jones

(b) Address 1905 V Ave St.

19. (a) 5-16-46 (b) Maedline Holmes  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 13, year 1946 hour 8: minute 20 A. M.

21. I hereby certify that I attended the deceased from May 10, 1946 to May 13, 1946  
that I last saw h er alive on May 13, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vascular Accident Duration                     

Due to Hypertensive Heart Disease

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                      (M. D. or other)                     

Address General Hospital No. 2 Date signed 5/13/46

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**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 *C. H. West*  
Licensed Embalmer No. 2710  
P. O. Address V. E. M. O.

**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.**