

S. No. 2  
M-5-43  
5-17-39  
P I X36671

**FILED SEP 9 1946**

Registrar's No. **3724**

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: St. Luke's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution since 8-12-46  
(Specify whether years, months or days)

In this community 60 years

**3. (a) PRINT FULL NAME** Mrs. Carrie Otterman Irwin

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 Lambdin E. Irwin 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased October 20 1873  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>72</u>	<u>10</u>	<u>8</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business X

**MOTHER, FATHER**

12. Name Dr. James L. Otterman

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

14. Maiden name Amanda S. Giles

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

16. (a) Informant Miss Mary Louise Irwin

(b) Address 7347 Main St., Kansas City, Mo.

17. (a) burial (b) Date, thereof 8-30-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-30-46 (b) Thereldine Holmea  
(Date received local registrar) (Registrar's signature)

**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. 7347 Main Street **8**  
(If rural, give location)

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

If yes, name country X

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 28  
year 1946 hour 6:50 minute P. M.

21. I hereby certify that I attended the deceased from Sept 6 1946 to Aug. 28 1946  
that I last saw her alive on Aug. 28 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Central Hemorrhage **2 yrs.**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 830  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy Central Hemorrhage  
Brain Parenchyma

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 0

23. Signature Dea C. Jones (M. D. or other) \_\_\_\_\_

Address 9 W. 85th Kansas City, Mo. Date signed 29 Aug 1946

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

APR 20 1949

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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

*J. Clair Shippard*

Licensed Embalmer No.

4179

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.**