

FILED OCT 28 1946
Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community 35 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson 48
(c) City or town Kansas City,
(If outside city or town limits, write "RURAL")
(d) Street No. 116 E 36 th
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sturdy, Ada
3. (b) If veteran, name war no 3. (c) Social Security No. none
4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 10 23 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 25 hr. min.

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

MOTHER, FATHER

11. Industry or business _____
12. Name Ferrell Sturdy
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Martin Sturdy
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jesse C. Sturdy
(b) Address Poplar Mo
17. (a) Removal (b) Date thereof 10-20-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Miller Mo

18. (a) Signature of funeral director Wm E R Foster
(b) Address 918 Brooklyn F.C.M.O.
19. (a) 10-19-46 (b) Heroldine Holman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 18 year 46 hour 9 minute 32 P.M.
21. I hereby certify that I attended the deceased from Oct. 12 1946 that I last saw her alive on Oct. 18 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Post operative lapotomy for intestinal obstruction;
Due to acute generalized peritonitis
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy see above

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) _____
(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 Wm W. Ford (M. D. or other) _____
Address Dr. Hoop. #1 Date signed 10-19-46

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..... *Coitland 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 the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4395

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: Gen. Hosp. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community 35 years
years, months or days)

3. (a) PRINT FULL NAME Ada Sturdy
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date of death (Month) (Day) (Year)

Place: burial or cremation _____

18. Signature of funeral director _____

(a) Address _____

(b) 10-19-46 Steraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 116 E. 36th
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18 year 1946 hour 9 minute 320 M.

21. I hereby certify that I attended the deceased from Oct. 12 1946 to 10-18 1946
that I last saw her alive on 10-18 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Post operative laparotomy for intestinal obstruction due to acute generalized peritonitis
Due to Rupture in intestines

Other conditions (Include pregnancy within 3 months of death) 1226

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature Wm. W. Hart (M. D. or other) _____
Address Gen. Hosp. #1 Date signed 10-19-46

MOTHER FATHER

6736
6736
6736

SUPPLEMENTARY
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Signature of physician
Cause of death
which death
could be
charged statistically.

