

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. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 DAYS**
(Specify whether
In this community **Over 10 years**
years, months or days)

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. **1007 VIRGINIA**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **11**

3. (a) PRINT FULL NAME **FANNIE HUBBARD**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **3 FEMALE** 5. Color or race **NEGRO**
6. (a) Single, widowed, married, divorced **WIDOWED**

6. (c) Age of husband or wife if alive **unknown** years

7. Birth date of deceased **AUGUST 20, 1886**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	3	11	hr. min.

9. Birthplace **TIPTON MISSOURI (1)**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEMAID**

11. Industry or business

12. Name **FRANK JOHNSON**

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

14. Maiden name **LUCY ?**

15. Birthplace **MISSOURI (1)**
(City, town, or county) (State or foreign country)

16. (a) Informant **MAMIE - COLEMAN (FRIEND)**

(b) Address **722 CAMPBELL**

17. (a) **Removal** (b) Date thereof **12-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Westlawn Cemetery**

18. (a) Signature of funeral director **Walter W. Thibault**

(b) Address **1520 N. 5th Street K.C.K.**

19. (a) **12-7-46** (b) **Seraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **1**,
year **1946** hour **3:** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **NOVEMBER 22**,
19 **46**, **DECEMBER 1**, 19 **46**

that I last saw h. ER. alive on **DECEMBER 1**, 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL THROMBOSIS** Duration

Due to **AMPUTATION OF LEFT FOOT**

Due to **Dry Gangrene**

Other conditions: **arteriosclerosis left foot**
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy **836**

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? **C-K**

While at work? (Specify type of place) (e) Means of injury **2**

23. Signature **E. Frank Lewis** (M. D. or other) **M. D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **12/2/46**

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 Nathan A. Katalan

Licensed Embalmer No. 2780

P. O. Address. 1520 N. 5th St

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.