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47370

COPIES ON HANDING BLACK INK—MAKE A PERMANENT RECORD

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:
219 WEST ARMOUR BLVD /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 54 YEARS

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 4

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 219 WEST ARMOUR BLVD.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME MRS NELLE TUTT MACKIE

3. (b) If veteran, No name war.

3. (c) Social Security No. NONE

4. Sex FEMALE / 5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MR. DAVID J. MACKIE SR.

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

7. Birth date of deceased MARCH 7 1890
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	9	2	hr. min.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name FRANKLIN R. TUTT

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

14. Maiden name SOPHIA IRVINE

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

16. (a) Informant MISS BARBARA MACKIE

(b) Address 219 WEST ARMOUR BLVD.

17. (a) BURIAL (b) Date thereof DEC-11-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEMETERY

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 12-10-46 (b) Geraldine Holman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 9TH year 1946 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from 12-8-46 to 12-9-46, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage 2 hrs

Due to: Hypertensive Cardiovascular Disease 7 yrs

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

Major findings: Of operations: X 9302

Of autopsy: X

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: _____ Date signed: 12/9/46

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 *Bernard L. Stover*
Licensed Embalmer No. *4250*
P. O. Address *AC Mo.*

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.