

FILED JAN 23 1947

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:
1117 East 11 St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community 40 yrs
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. 1117 East 11 St
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lulu Pearl Glover

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Femal / 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Carey C. Glover 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 13 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 2 23 hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

12. Name John Wilson

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

14. Maiden name Eliza Jane Altman

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

16. (a) Informant Addie A. Moss

(b) Address 1409 Agnes

17. (a) Removal (b) Date thereof Jan 8 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paola Kansas

18. (a) Signature of funeral director Mrs CLL Forster

(b) Address 918 Brooklyn

19. (a) 1-7-47 (b) Sheraldine Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6
year 1947 hour 6 minute 10 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Reputy Coronar
Ruptured aneurism

Due to Aortic - Suetic

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy See Above

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)
Means of injury _____

23. Signature A. E. Upsher (M. D. or other) MD
Address 2800 Main Date signed 1/7/47

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

MOTHER FATHER

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..... *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address..... *918 Brooklyn
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.