

Registration District No. 149 Primary Registration District No. 1002

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town K.C.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: H.C.T.B.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 mo. 14 da.
 (Specify whether
 In this community 3 yrs.
 ; years, months or days)

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. 3219 Smart
 (If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country.

3. (a) PRINT FULL NAME Mrs. Kathleen Horton
 3. (b) If veteran, name war no. 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 10
 year 1947 hour 9 minute 30 A.M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Truman Horton 6. (c) Age of husband or wife if alive 46 years
 7. Birth date of deceased: June 27 1900
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 27 - 1947 to Jan. 10 1947
 that I last saw her alive on Jan. 10 1947
 and that death occurred on the date and hour stated above.

8. AGE: Years 46 Months 6 Days 13 If less than one day hr. min.

Immediate cause of death Pulmonary Tuberculosis Duration 8 yrs.

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

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

10. Usual occupation Housewife

11. Industry or business Home
 12. Name Charles Lane
 13. Birthplace Calif.
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Boswell
 15. Birthplace Calif.
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant H.C.T.B. Hosp.
 (b) Address K.C., Mo.

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? _____

17. (a) Removal (b) Date thereof 1-11-47
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Hope R.C.K.

18. (a) Signature of funeral director Mrs. C. H. Gaster
 (b) Address 918 Northlyn K.C. Mo.

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature M. B. Pennington (M. D. or other)
 Address H.C.T.B. Hosp. Date signed _____

19. (a) 1-11-47 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

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

C. H. Wise

Licensed Embalmer No. *2570*

P. O. Address *100 ms*

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.