

No. 2
-5-43
5-17-39
I X36671

FILED JAN 23 1947
Registration District No. 149

Primary Registration District No. 1802

Registrar's No. _____

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:
504 West 14th. Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community 50 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town 504 West 14th, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 504 West 14th. Street
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-7 day 47
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 1-1-46
1-7-47, 19____, to _____, 19____.
that I last saw her alive on 1-7-47
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 1 yr.
Arterio Sclerosis 10 yrs
Due to Senility 10 yrs
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations no
Of autopsy no
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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? _____ (i) Means of injury _____
23. Signature W.A. Cascholt M.D. of other _____
Address 4000 Ballouree K.C. Mo. Date signed 1-7-47

3. (a) PRINT FULL NAME Mattie R. Lindell

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 Widow

6. (b) Name of husband or wife August Lindell 6. (c) Age of husband or wife if alive * years

7. Birth date of deceased 11 16 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 1 21 hr. _____ min.

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

10. Usual occupation At. Home

11. Industry or business _____

12. Name William W. Richards

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

14. Maiden name Lida Corbey

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

16. (a) Informant Mrs. Mattie R. Lindell

(b) Address 504 West 14th. K.C. Mo.

17. (a) Burial (b) Date thereof 1-8-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park K.C. Kans.

18. (a) Signature of funeral director Mrs. C.L. Forster
Kansas City, Missouri

(b) Address _____

19. (a) 1-8-47 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

Case 602 dx
40 Baltimore
U.A. 5115

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
N. E. 1 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.