

FILED MAR 25 1947
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 **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Research Hospital**
(If not in hospital or institution, write street number or location) **36 hrs**
(d) Length of stay: In hospital or institution **32 yrs** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Edith Leona Lusby**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Everett E. Lusby** 6. (c) Age of husband or wife if alive **57** years
7. Birth date of deceased **Oct 10 1883** (Month) (Day) (Year)

8. AGE: Years **63** Months **5** Days **4** If less than one day hr **1** min

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER

12. Name **Ans. J. Busby**
13. Birthplace **no record** (City, town, or county) (State or foreign country)
14. Maiden name **Clara Beane**
15. Birthplace **Ind. 1** (City, town, or county) (State or foreign country)

16. (a) Informant **Everett E. Lusby**

(b) Address **2904 Olive**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Mar 16 1947** (Month) (Day) (Year)

(c) Place: burial or cremation **Garden City Mo**

18. (a) Signature of funeral director **W. C. Foster**

(b) Address **918 Broadway**

19. (a) **3-15-47** (Date received local registrar) (b) **Sheldine Holms** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City** 3
(If outside city or town limits, write "RURAL")
(d) Street No. **2904 Olive** 8
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14**
year **1947** hour **6** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **March 12** 19**47** to **March 14** 19**47**
that I last saw her alive on **March 13** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **Approx. 36 hrs**

Due to **Hypertension**

Due to

Other conditions **none** 830
(Include agency within 3 months of death)

Physician **Adrian J. Brown, M.D.**

Major findings: Of operations **none**

Of autopsy **none**

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) (c) Means of injury

23. Signature **Adrian J. Brown** M. D. or other **M.D.**

Address **350 E. Pinour Blvd** Date signed **3-14-47**

Dr. A. J. Brown

9/20/18

2 1/2

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 Carthaus Minor

Licensed Embalmer No. 3414

P. O. Address. 918 Brooklyn

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.