

Registration District No. 47

Primary Registration District No. 2008

1. PLACE OF DEATH:

(a) County Calloway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 yrs. Mo. 24  
(Specify whether years, months or days)  
In this community same

3. (a) PRINT FULL NAME KATIE QUINN  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 15 1881  
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 0  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Katie Quinn  
13. Birthplace Scotland  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Coburn  
15. Birthplace Scotland  
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hosp No. 1  
(b) Address Fulton Mo.  
17. (a) Removal (b) Date thereof 5-23-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation of Miss Terrell

18. (a) Signature of funeral director J. Ferguson  
(b) Address 2515 Halpin  
19. (a) 5-24-1947 (b) Joan Mosenkoff  
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15  
year 1947 hour 11 minute 53 P. M.  
21. I hereby certify that I attended the deceased from May 10  
10 1947 to May 15 1947  
that I last saw her alive on May 15 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Obstructing primary carcinoma of uterus  
Hypertensive Pneumonia  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations \_\_\_\_\_  
Of autopsy same

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 R. Price (M.D. or other) \_\_\_\_\_  
Address Fulton Date signed 5/16/47

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

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

14  
1  
2

109 - W - 7<sup>th</sup> St.

JUN 3 1947

RECEIVED  
District Health Officer No. 9

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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.....

Licensed Embalmer No. 2361

P. O. Address 2512 Halms St

**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.