

S. No. 300  
M-10-47  
v. 5-17-39  
I 3906

FILED FEB 23 1948  
Registration District No. 249

Primary Registration District No. 1002

Registrar's No. 595

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:  
Hyde Park Nursing Home 401 E. 36th St 4  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 Months  
(Specify whether  
 In this community 1 yr. 4 Months  
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. 15 W 57th  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME Mrs. Kathrine E. Longfellow  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 9th  
 year 1948 hour 6 minute 30 A.M.  
 21. I hereby certify that I attended the deceased from 11-2-46  
 \_\_\_\_\_, 19\_\_\_\_, to 2-9, 1948;  
 that I last saw her alive on Dec, 1947  
 and that death occurred on the date and hour stated above.

4. Sex F / 5. Color or race W  
 6. (a) Single, widowed, married, divorced None  
 6. (b) Name of husband or wife Mr. Geo. E. Longfellow  
 6. (c) Age of husband or wife if alive unk years  
 7. Birth date of deceased Sept 23 1872  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 2 days  
 Due to Cerebral Arterio Sclerosis years  
 Due to \_\_\_\_\_  
 Other conditions Comulsion seizures 2 yrs.  
(Include pregnancy within 3 months of death)

8. AGE: Years 75 7/4 Months 4 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Covington Penn 1  
(City, town, or county) (State or foreign country)  
 10. Usual occupation At Home

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 830

MOTHER FATHER {  
 11. Industry or business \_\_\_\_\_  
 12. Name John B. Grom 4  
 13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Leopoldine Chrothinger  
 15. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Geo. Longfellow  
 (b) Address 15 W 57th St  
 17. (a) Removal (b) Date thereof Feb 10 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Denver Colo.  
 18. (a) Signature of funeral director D. W. Newcomers  
 (b) Address 1401 Brushy Creek  
 19. (a) 2-10-48 (b) Theraldine Holmes  
(Date received local registrar) (Registrar's signature)

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?  
 \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature [Signature] (M. D. or other) MD.  
 Address [Signature] Date signed 2-10-48

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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 Jess T. Dewe  
Licensed Embalmer No. 4453  
P. O. Address Kansas City

**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.**