

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:
1730 Corrington Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **30 yrs.** (Specify whether years, months or days)

In this community **30 yrs.**

3. (a) PRINT FULL NAME **Gertrude V. Skaggs**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **495-20-1482**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **3 divorced Divorced**

6. (b) Name of husband or wife **Robert Skaggs** 6. (c) Age of husband or wife if alive **24** years

7. Birth date of deceased **January 24, 1891**
(Month) (Day) (Year)

8. AGE: Years **51** Months **5** Days **7** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Ed Husted**

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

14. Maiden name **Martha Owens**

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

16. (a) Informant **John L. Skaggs**

(b) Address **1730 Corrington**

17. (a) **Burial** (b) Date thereof **9/3/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LaCygne, Kansas**

18. (a) Signature of funeral director **Earp & Sons**

(b) Address **4139 East 15th Street**

19. (a) **9-2-48** (b) **Deraldine Holmes**
(Date received local registrar) (Registrar's signature)

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. **1730 Corrington**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Sept** day **15th** year **1948** hour **6** minute **20** M.

21. I hereby certify that I attended the deceased from **Sept 10** 19**48** to **Sept 11** 19**48**

that I last saw h. **Ed** alive on **Sept 1** 19**48** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **Hypertension**

Duration **3 days**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **830**

Of autopsy

PHYSICIAN 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) (b) Means of injury **2**

23. Signature **J. J. Szelkowski** (M. D. or other) **1001 Belmont** Date signed **9/2/48**

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.....

James W. Camp....., Registered Apprentice No. *203*
working under my personal supervision.

Signed *John B. Camp*.....
Licensed Embalmer No. *2555*
P. O. Address *2555*.....

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.