

No. 2
5-543
5-17-39
I X36671

FILED NOV 16 1948

Registration District No. **199**

Primary Registration District No. **1002**

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: Shea Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 Days
(Specify whether years, months or days)

In this community 5 Months
(Specify whether years, months or days)

3. (a) PRINT FULL NAME MARGARET ELVINA HAMILTON

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, Widowed

6. (b) Name of husband or wife Alex. B.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased February 16, 1861
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>8</u>	<u>13</u>	<u>hr. min.</u>

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

10. Usual occupation Invalid

11. Industry or business At Home

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. R. L. Hempel

(b) Address 944 W. 34th.

17. (a) Removal
(Burial, cremation, or removal)

(b) Date thereof 10-30-48
(Month) (Day) (Year)

(c) Place: burial or cremation Laramie, Wyo.

18. (a) Signature of funeral director C.H. Blackman & son Inc.

(b) Address Kansas City

19. (a) 10-30-48
(Date received local registrar)

(b) Sheraldine Holmes
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wyoming (b) County Albany

(c) City or town Laramie
(If outside city or town limits, write "RURAL")

(d) Street No. 716 Iverson
(If rural, give location)

(e) Citizen of foreign country? No
(Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29
year 1948 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug 16-48
19 to Oct 29 1948

that I last saw her alive on Oct 29 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Bronchopneumonia **Duration 2 days**

Due to Fractured hip **2 1/2 mo**

Due to _____

Other conditions Hypertension **for 2 yrs**
(Include pregnancy within 6 months of death)

Major findings: 1860

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 8-16-48 **133**

(c) Where did injury occur? N.C. Jackson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
944 W. 34th St.

J. W. Grauerholz
(Specify type of place)

While at work? No (e) Means of injury fall

Signature J.W. Grauerholz M.D. (M. D. or other)

Address 3527 Broadway, Kansas City, Mo Date signed Oct 29 48

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. Grandhoy
3527 Bldg
we 5522
Trinity

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 D. Grandhoy, Registered Apprentice No. 274, working under my personal supervision.

Signed O. K. McFarland
Licensed Embalmer No. 4397
P. O. Address Kansas City, 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.