

S. No. 2
M-5-43
5-17-39
I X36671

FILED NOV 20 1948

Registration District No. **149** 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:
Hyde Park Nursing Home 401 East 36th. St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. **5 Years** **4**
(Specify whether years, months or days)

In this community **5 Years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **U.S.**

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

(d) Street No. **401 East 36th. Street**
(If rural, give location)

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

3. (a) PRINT FULL NAME **SARAH FRANCES HERTSLET**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow** **2**

6. (b) Name of husband or wife **Clement T. Hertslet** 6. (c) Age of husband or wife if alive ***** years

7. Birth date of deceased **10 25 1865**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **23rd.**
year **1948** hour **12** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **1945**
19 **October 23** 19 **48**
that I last saw her alive on **Oct. 18** 19 **48**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

82 **11** **23** hr. min.

Immediate cause of death **Cancer of the rectum** **about a year.**

Due to **do not know**

Due to **4th**

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

10. Usual occupation **At Home**

Other conditions **bad mitral lesion, and a nephritis**
(Include pregnancy within 3 months of death) **about 3 years**

Arthritis deformans **PHYSICIAN**

MOTHER, FATHER

11. Industry or business

12. Name **James Church**

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

14. Maiden name **Harriett Guinn**

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

Major findings:
Of operations
Of autopsy

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr. Clement T. Hertslet**

(b) Address **5813 Garfield**

17. (a) **Removal** (b) Date thereof **10-26-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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?

18. (a) Signature of funeral director **Mrs. C.L. Forster**
(b) Address **Kansas City, Missouri**

19. (a) **10-25-48** (b) **Steraldine Holmes**
(Date received local registrar) (Registrar's signature)

James W. Graham (Specify type of place) **D**
While at work (c) Means of injury

23. Signature **James W. Graham** (M. D. or other)
Address **578 Argyle Bldg.** Date signed **10/23/48**

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

Dr. James Graham

Argyle Bldg.

2 - 4/30

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 *Robert H. Ferrman*

Licensed Embalmer No. *3700*

P. O. Address *KOMO*

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.