

13-300
10-47
17-39
1-3908

Registration District No. 749

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:
Krestwood Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days 4
In this community 60 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson 999
(c) City or town Kansas City "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. 5208 Delmar 2
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Miss Sarah Russell

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

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 1883 years

7. Birth date of deceased: Sept. 15 (Month) (Day) (Year)

8. AGE: 65 Years 1 Months 21 Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name Samuel Russell

13. Birthplace: No Record (City, town, or county) Ireland (State or foreign country)

14. Maiden name Catherine Kane

15. Birthplace: No Record (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Miss Bessie Russell

(b) Address 5208 Delmar

17. (a) Burial Cem. (Burial, cremation, or removal) (b) Date thereof 11/8/48 (Month) (Day) (Year)

(c) Place: burial or cremation Shawnee Cem. SHAWNEE, KANS.

18. (a) Signature of funeral director Gates Funeral Home

(b) Address 1901 Olathe Blvd., K. C., Kans

19. (a) 11-9-48 (Date received local registrar) (b) Steraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6
year 1948, hour 2:50 minute P.M.

21. I hereby certify that I attended the deceased from 1948, 1948, to 11-6- 1948
that I last saw her alive on Nov. 6, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension
apoplexy
of left brain. Duration _____
Due to _____

Due to _____
Other conditions Chronic arthritis
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations 12/1/48
Of autopsy _____
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? _____

B. I. Myers (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature B. I. Myers (M. D. occupation) _____

Address 1115 Grand Ave Date signed 11-7-48

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

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 *W. L. Ward*

Licensed Embalmer No 3991

P. O. Address 308 East 68th St
St. Paul, Minn.

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.