

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 6 mo.		d. STREET ADDRESS (If rural, give location) 3811 Broadway	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3811 Broadway			

3. NAME OF DECEASED a. (First) Kathleen b. (Middle) Grandall c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) Sept 21-50		
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5. SEX Female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Aug 19-47		9. AGE (In years last birthday) 3		# UNDER 1 YEAR Months Days		# UNDER 1 MRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Nebr /				12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Adelvie Grandall		13b. MOTHER'S MAIDEN NAME Do not know		14. NAME OF HUSBAND OR WIFE _____			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Adelvie Grandall Hartington Nebr			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration pneumonia						INTERVAL BETWEEN ONSET AND DEATH 24 hours	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral palsy						Birth	
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. malnutrition						35 1/2	

19a. DATE OF OPERATION now		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from **Aug. 1950**, to **Sept 20 1950**, that I last saw the deceased alive on **Sept 20, 1950**, and that death occurred at **6:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE James D. Watson MD (Degree or title)		23b. ADDRESS 6153 Oak St. Kansas City 2, Mo.		23c. DATE SIGNED 9/21/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Sept 21-50		24c. NAME OF CEMETERY OR CREMATORY Hartington		24d. LOCATION (City, town, or county) (State) Hartington Nebr	
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DATE REC'D BY LOCAL REG. 9-22-50		REGISTRAR'S SIGNATURE Sheralding Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pussantino Bros KC Mo	
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WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Harold Eckternacht*

Licensed Embalmer No. *1551*

P. O. Address *Kansas City, Kansas*

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.