

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1328 Troost
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 Yrs.
(Specify whether years, months or days)

NOV 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 1328 Troost
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1st.
year 1939 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Edema

Due to Myocardial Failure

Due to Not known

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Cerebral Edema

Duration

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) (e) Means of injury _____

23. Signature Russell J. Sen (M. D. or other) 4
Address Kans Date signed _____

3. (a) PRINT FULL NAME Miss Louellen Day Stevens

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Thack Stevens 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased March 19th 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 6 Days 12 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER
12. Name George Day
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Hasty
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature George Day

(b) Address Ottawa Kansas

17. (a) Removal (b) Date thereof 10/2/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ottawa Kans

18. (a) Signature of funeral director Th. J. Mayberry

(b) Address 2315 Linwood Blvd

19. (a) Oct 2 1939 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

R. E. Snow, Registered ^{Embalmer}~~Apprentice~~ No. 2560

working under my personal supervision.

Signed W. Mayberry
Licensed Embalmer No. 2934

P. O. Address.....

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, above space should be left blank.