

DEC 11 1935
Registration District No. 297

Primary Registration District No. 1002

Registrar's No. 4442

1. PLACE OF DEATH:
(a) County Jackson 2
(b) City or town Kansas City
(c) Name of hospital or institution:
1013 Euclid
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Two years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ELLA CARTER
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F 5. Color or race Col. 6. (a) Single, widowed, married, divorced Mar.
6. (b) Name of husband or wife Carl Carter 6. (c) Age of husband or wife if alive unk. years
7. Birth date of deceased June 6 1895
(Month) (Day) (Year)

8. AGE: Years 44 Months 4 Days 28 If less than one day _____ hr. _____ min.

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

10. Usual occupation Domestic
11. Industry or business 0
12. Name Mrs M. Nancy 0
13. Birthplace Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Ellen Terrell
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Helen Lewis
(b) Address 1013 Euclid
17. (a) Burial (b) Date thereof 11-21-35
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge
18. (a) Signature of funeral director Higgins Bros
(b) Address 1729 Lydia
19. (a) Nov 21 1935 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1013 Euclid
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 4 day Nov.
year 1935 hour _____ minute 5:30 P. M.
21. I hereby certify that I attended the deceased from Jan 15
1935 to Nov 4 1935
that I last saw her alive on Nov 4 1935
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Asthma 2 yrs
Due to _____
Due to " Chronic Interstitial Nephritis 1 yr.
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____
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 typical place) _____
(e) Means of injury _____
23. Sign Edward R. Kelly (M. D. or other) _____
Address 1619 E. 24th St. Date signed _____

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.

1 X1951

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.....

Robert M. Adams

Registered Apprentice No. *178*

working under my personal supervision.

Signed *J. B. Hopkins*

Licensed Embalmer No. *2889*

P. O. Address *1729 Lydia*

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.