

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City Mo.  
(c) Name of hospital or institution: St. Joseph Hospital.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 46 years  
In this community 46 years  
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Miss Alice ALYWARD. 463  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 15th, 1893  
(Month) (Day) (Year)

8. AGE: Years 46 Months 0 Days 26 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City - Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_  
12. Name T. J. Alwyard.  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Katherine Walsli  
15. Birthplace Ireland.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Alwyard.  
(b) Address 104 West 9th.

17. (a) Burial (b) Date thereof 12/16/39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Melody-McGilley.  
(b) Address K. C. Mo.

19. (a) Dec. 15, 1939 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

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. 3326 Wayne Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 14  
year 1939 hour 2 minute 10 P. M.  
21. I hereby certify that I attended the deceased from 12-13  
1939, to 12-14, 1939;  
that I last saw h. alive on 12-14, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Pneumonia  
Wernicke Encephalopathy

Due to 50  
Due to \_\_\_\_\_

Other conditions Carcinoma Breast with Metastases to Bones  
(Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy No

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) No  
(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 M. M. Brown M.D.  
Address 734 Adelphi Bldg Date signed 12-14-39

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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.

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**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.....

Licensed Embalmer No.....

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.**