

Registration District No. **399** Primary Registration District No. **1002**

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. 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: St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 Days  
(Specify whether years, months or days)  
 In this community About 50 Years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 6141 Charlotte Ave.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Mrs. Katherine Berger **626**  
 3. (b) If veteran, name war No 3. (c) Social Security No. None

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month December day 23rd  
 year 1939 hour 8 minute 15 P. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 6. (b) Name of husband or wife Morris H. Berger  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 9, 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 2, 1939  
 \_\_\_\_\_, 19 \_\_\_\_\_ to Dec 23, 1939  
 that I last saw her alive on Dec 23, 1939  
 and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
70 9 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Pneumonia Secondary to Cocciemia of Sigmoid  
 Due to \_\_\_\_\_ 46  
 Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Ca of Sigmoid  
 Of operations \_\_\_\_\_  
 Of autopsy Ca of Sigmoid & P. enteritidis

10. Usual occupation Housework

11. Industry or business At Home  
 12. Name Robert Hamilton  
 13. Birthplace Unknown Scotland  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary McPeeters  
 15. Birthplace Unknown Ireland  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_  
(Specify type of place)  
 While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant's own signature E. D. Mitchell  
 (b) Address 6141 Charlotte

17. (a) Burial (b) Date thereof Dec. 26, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director W. C. McCombs  
 (b) Address 1401 Brush Creek Blvd.

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address 1414 P. City Bldg. Date signed 12/23/39

19. (a) Dec 24, 1939 (b) M. L. Lawrence  
(Date received local registrar) (Registrar's signature)

W. Staples  
53196th  
1 P.M.

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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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. C. Mo.

**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.