

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.

Registration District No. 399

Primary Registration District No. 1002

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
Unk. (Specify whether
 In this community _____
 years, months or days)

8. (a) PRINT FULL NAME Sadie Wurtz 632

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife Robert W. Wurtz 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 18, 1871
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>8</u>	<u>13</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name David Davis

13. Birthplace Wales England
(City, town, or county) (State or foreign country)

14. Maiden name Ann Price

15. Birthplace Wales England
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. E. Lonsdale

(b) Address 2528 Hardesty

17. (a) Burial (b) Date thereof January 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Wm. Henderson

(b) Address 1626 Michigan St. K.C. Mo.

19. (a) Dec. 31, 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
(If outside city or town limits, write "RURAL")
 (d) Street No. 3601 Wabash
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31st
 year 1939 hour 6 minute 20 P. M.

21. I hereby certify that I attended the deceased from 12-30-39, 19____, to 12-31-39, 19____;
 that I last saw her alive on 12-31-39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Hypostatic bronchopneumonia

Due to Myocardial insufficiency

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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 Dr. De Munn (M. D. or other)
 Address Supt. K.C. Gen. Hospital Date signed 1-2-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 *J. C. Henderson*

Licensed Embalmer No. *3657*

P. O. Address *N. C. Me*

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.