

REC'D MAR 1 - 1940
Registration District No. 399

Primary Registration District No. 1002

State File No. _____
Registrar's No. 647

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: General Hospital No. 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1-29-40-2-1-40
(Specify whether years, months or days) 65 years

3. (a) PRINT FULL NAME Evelyn Mott

8. (b) If veteran, name war None 8. (c) Social Security No. None

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased June 25 1868
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 7 If less than one day hr. min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown Hiram Jackson

13. Birthplace Unknown Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Add.

15. Birthplace Unknown Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital No. 2.

17. (a) Burial (b) Date thereof Feb. 13 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Walters Bros.

(b) Address 1729 Lydia

19. (a) Feb. 12, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2011 E. 9th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 1
year 40 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1-29, 19 40, to 2-1, 19 40;
that I last saw her alive on 2-1, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage.

Due to 82a

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 [Signature] (M. D. or other) _____

Address General Hospital #2 Date signed 2-5-

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.

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 Isaac Jerome Manlove
Licensed Embalmer No. 3994
P. O. Address 1120 E. 23rd St

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.