

1. PLACE OF DEATH:

(a) County. Jackson
(b) City or town. Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3510 East 43rd. St. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community. 15 Years
years, months or days)

3. (a) PRINT FULL NAME. Marie L. Giddings 352

3. (b) If veteran, name war. None 3. (c) Social Security No. None

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. December 21- 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
24 3 17 hr. _____ min.

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

10. Usual occupation. At. Home

11. Industry or business. 1

12. Name. John Giddings

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

14. Maiden name. Julia Thrift

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

16. (a) Informant. Mr. John Giddings

(b) Address. 3510 East 43rd. St.

17. (a) Burial (b) Date thereof. 4-11-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Greenlawn

18. (a) Signature of funeral director. Mrs. C.L. Fenster

(b) Address. 918 Benton Rd. N.E. Mo.

19. (a) April 9, 1940 (b) M. N. Crowe
(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 limit, write "RURAL")
(d) Street No. 3510 East 43rd.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month. April day. 8
year. 1940 hour. 11 minute. 10 A. M.

21. I hereby certify that I attended the deceased from 3-240
_____, 19____, to 4-8, 1940
that I last saw her alive on 4-8-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Tuberculosis 1 yr.

Due to. 23
Due to. _____

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

Major findings: None
Of operations. _____

Of autopsy. No post

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. 10

23. Signature. Bernard T. Volz (M. D. or other)
Address. 900 Benton Rd. N.E. Mo. Date signed 4-9-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

902 West
A. D. 66 D
about 2:00 P.M.

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

Denzil C. Browning

Licensed Embalmer No. *2724*

P. O. Address *A. C. mfg*

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.