

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1562**

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 **9 Days**
(Specify whether years, months or days)
 In this community **9 Days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**
 (c) City or town **Sullivan**
(If outside city or town limits, write "RURAL")
 (d) Street No. **-----**
(If rural, give location)
 (e) If foreign born, how long in U. S. A? **-----** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **11th**
 year **1940** hour **4** minute **20 P. M.**

21. I hereby certify that I attended the deceased from **4-6-40**
4-10-40, 19, to **4-11-40**, 19;
 that I last saw her alive on **4-11-40**, 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Generalized carcinoma**
curcunomatosis

Duration
Five

Due to **Primary carcinoma of uterus**
46

Other conditions **Bilateral hydrothorax**
(Include pregnancy within 5 months of death)

PHYSICIAN

Major findings:
 Of operations
 Of autopsy **Generalized carcinoma of uterus**

Underline the cause to which death should be charged statistically.

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) (By means of injury)

23. Signature **Wm. M. Crowe M.D.**
721 Prof (M. D. or other)
 Address _____ Date signed **4-11-40**

3. (a) PRINT FULL NAME **Mrs. Flora Jane Cline 150**

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

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

6. (b) Name of husband or wife **Mr. John J. Cline** 6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **February 22 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 1 19 hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **-----**

12. Name **John G. Miller**

18. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

14. Maiden name **Harriet Love**

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

16. (a) Informant **Class A Miller**
 (b) Address **4328 Walnut Street**

17. (a) **Removal** (b) Date thereof **April 12, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or crematory **Beloit, Kansas**

18. (a) Signature of funeral director **D. V. Newcomer's Sons**
 (b) Address **1401 Brush Creek Blvd**

19. (a) **April 12, 1940** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

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

721 Professional - 12-2

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address D. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.