

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. 10 15 699

Primary Registration District No. 1002

Registrar's No. 1650

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. Mary's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community all her life
years, months or days

3. (a) PRINT FULL NAME Grace Althoff Easterling
 3. (b) If veteran, name war -----
 3. (c) Social Security No. No

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife F. D. Easterling
 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased Sept. 18, 1890 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 6 29 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____
 12. Name Louis H. Althoff
 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Emma Fuerhoff Illino
(City, town, or county) (State or foreign country)
 15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature F. D. Easterling
 (b) Address 339 Division

17. (a) burial (b) Date thereof 4-19-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill
 18. (a) Signature of funeral director Walter Funeral Home
 (b) Address Kansas City, Kansas

19. (a) 4-18-1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Kansas (b) County Wyandotte
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 339 Division
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 16
 year 1940 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from Apr. 5, 1940
 _____, 19____, to Apr. 16, 1940, 19____;
 that I last saw her alive on Apr. 16, 1940, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration Apr. 5, 1940

Due to 16/40

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

Major findings:
 Of operations _____
 Of autopsy Bronchial Pneumonia

PHYSICIAN

 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) (e) Means of injury 1

23. Signature [Signature] (M. D. or other) _____
 Address 401 S. W. Blvd Date signed 4/17/40

J. W. Young
1401 Southwest Blvd.

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

D. Ross Blanford

Licensed Embalmer No. *3015*

P. O. Address *1815 W 41*

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.