

FILED MAY 17 1940

Registration District No. 700

Primary Registration District No. 5552B

Registrar's No. 84

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

1. PLACE OF DEATH:

(a) County Jackson Prairie Mo.
(b) City or town Jackson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson Co Home 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 months
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME MARY NICHOLS 242

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

4. Sex Fe 5. Color or race negro 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation domestic

11. Industry or business None known

12. Name None known

13. Birthplace None known (City, town, or county) (State or foreign country)

14. Maiden name None known

15. Birthplace None known (City, town, or county) (State or foreign country)

16. (a) Informant Rebecca McWel

(b) Address 1313 Virginia

17. (a) Removal (b) Date thereof 4-20-40 (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville Mo

18. (a) Signature of funeral director Wm. J. Brewster

(b) Address 1819 E. 12th Kc Mo 432

19. (a) 4-18-40 (b) San G. Bains (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. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17 year 1940 hour 1:40 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 15 - 1940 to April 17 - 1940 that I last saw him alive on April 17 - 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to Stroke

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? _____

18. (a) Signature of physician L. W. Booker (Specify type of place) (c) Means of injury _____

23. Signature L. W. Booker (M. D. or other) _____

Address 2028 Vine St Date signed 4/18/40

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 Edward S. Evans.

Licensed Embalmer No. 3836

P. O. Address.....

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.