

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

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:  
3227 East 10th  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 27 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3227 East 10th  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7  
year 1940 hour 2 minute 27 AM.

21. I hereby certify that I attended the deceased from Oct 3, 1940, to Oct 6, 1940  
that I last saw him alive on Oct 6, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 4 days

Due to \_\_\_\_\_  
Due to Arterio Sclerosis

Other conditions (Include pregnancy within 3 months of death) §2.00

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_

23. Signature R. H. Williams (M. D. or other) \_\_\_\_\_  
Address 5400 St. John Ave Date signed 10/7-40

8. (a) PRINT FULL NAME Emma May Fairchild

8. (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 Widowed

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

7. Birth date of deceased Oct. 12, 1869  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) Ohio (State or foreign country)

10. Usual occupation House Work

11. Industry or business \_\_\_\_\_

12. Name Conrad Coder

13. Birthplace Ohio (State or foreign country)

14. Maiden name Unk. Barnes

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

16. (a) Informant William H. Coder

(b) Address 330 South Oakley

17. (c) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-40  
(Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

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

(b) Address 918 Brooklyn Kansas City

19. (a) 10-10-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

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

Be. 2695

**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 *R. C. no*

**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.**