

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4194**

I. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City, Mo.**
 (If outside city or town limits, write "RURAL" and name of neighborhood)
 (c) Name of hospital or institution **Wheatley Provident Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **6 months 1**
 (Specify whether years, months or days) **28 yrs.**

3. (a) PRINT FULL NAME **HARRIETTE BAILEY SPRAGUE**

8. (b) If veteran **Harriette Bailey Sprague** State Security name war **no** No. **now**

4. Sex **Female** 5. Color or race **negro** 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 **Nov 27 1871**
 (Month) (Day) (Year)

8. AGE: Years **69** Months **0** Days **2-6** If less than one day hr. min.

9. Birthplace **Rochester N.Y.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **School Teacher**

11. Industry or business **Princess Inn Academy, MD**

12. Name **Nathan Sprague**

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

14. Maiden name **Roseetta Douglas**

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

16. (a) Informant **Fredricka Perry**

(b) Address **2451 Montgall**

17. (a) **Burial** (b) Date thereof **11-13-1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rochester N.Y.**

18. (a) Signature of funeral director **Thom + Breadhead**

(b) Address **1819 E. 15 St. No**

19. (a) **11-3-40** (b) **M. M. 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**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2451 Montgall**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **1st**
 year **1940** hour **12** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **April 18th** 19**40** to **Nov 1st** 19**40**
 that I last saw **her** alive on **Nov 1st** 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Dilatation** Duration **1 day**

Due to **hypertension** **12 yr**

Due to **Arteriosclerosis** **24 yr**

Other conditions **Colitis 95B** **27 yrs**
 (Include pregnancy within 3 months of death)

Major findings: **none** PHYSICIAN _____
 Of operations _____

Of autopsy **none** 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) **0**

(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) (Means of injury)

23. Signature **Thos. J. Crowe** (M. D. or other) _____

Address **1612 E 12th** Date signed **11/1/40**

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

REC'D DEC 2 1940

MOTHER FATHER

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

Edo Kovacs

Licensed Embalmer No.

3836

P. O. Address

1819 E 15th Ave

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.