

Registration District No. 399
Primary Registration District No. 1002

FILED DEC 11 1940

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: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri (a) State (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4411 Scarritt (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME CORA HENRY

3. (b) If veteran, name war --- 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 4th 1886
(Month) (Day) (Year)

8. AGE: Years 54 Months 9 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name No record

13. Birthplace " " _____
(City, town, or county) (State or foreign country)

14. Maiden name " " _____

15. Birthplace " " _____
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K.C. Gen. Hospital

17. (a) Burial (b) Date thereof 11-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia, Mo.

18. (e) Signature of funeral director Ewing Funeral Home
Sedalia, Missouri.

(b) Address _____
19. (a) 11/12/40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9th
year 1940 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from 10-28-40, 19____, to 11-9-40, 19____;
that I last saw her alive on 11-9-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic left empyema; Cardiac hypertrophy and Dilatation right heart;
Due to Chronic passive congestion right lung;
Due to _____

Duration

Other conditions Chronic passive congestion of liver with secondary cirrhosis.
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy See above

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) Means of injury 1
23. Signature Drury R. Shon (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

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.....

Licensed Embalmer No.....

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.