

Registration District No. **399**

Every Registration District No. **1002**

Registrar's No. **4445**

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: **Kansas City Municipal Tuberculosis Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 mo - 23 day**
 (Specify whether
 In this community **20 years**
 years, months or days)

3. (a) PRINT FULL NAME **Carlson, Hazel**

8. (b) If veteran, name war **No** 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 **Clarence Carlson** 6. (c) Age of husband or wife if alive **35** years
 7. Birth date of deceased **Feb. 14 - 1903**
 (Month) (Day) (Year)

8. AGE: Years **38** Months **9** Days **7** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER
 12. Name **McKenney, Jim**
 13. Birthplace **Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Kraup, Mary**
 15. Birthplace **Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **H.C.M. J.B. Knight**

(b) Address **Leeds Station**

17. (a) **Burial** (b) Date thereof **11-23-1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **Mrs. P. J. Forster**

(b) Address **Rt. 2, Mo.**

19. (a) **11-22-40** (b) **M. M. Brown**
 (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. **1016 Locust**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **21st**
 year **1940** hour **four** minute **00** A.M.

21. I hereby certify that I attended the deceased from **May 29th**
1940 to **Nov. 21st**, 19**40**.

that I last saw her alive on **Nov 20**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**
 Due to **Anterior tubercles**

Due to **23**

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **W.C. Th. Hospital** (M. D. or other)
 Address **W.C. Th. Hospital** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

COPY ON CONTAINING 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 Cheron A. Redman

Licensed Embalmer No. 2737

P. O. Address P.O. 710

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.