

Registration District No. **399**

Primary Registration District No. **1002**

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 General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. & 11 days**
(Specify whether years, months or days)
In this community **8 Years**

3. (a) PRINT FULL NAME **EFFIE STUART**

3. (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, **Widowed**
6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **21** years **1866**
7. Birth date of deceased **March 21**
(Month) (Day) (Year)

8. AGE: Years **74** Months **10** Days **4**
If less than one day hr. min.

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

10. Usual occupation **None**

11. Industry or business

12. Name **Unknown**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Record Clerk**

(b) Address **K. C. General Hospital**

17. (a) **Removal** (b) Date thereof **Jan. 26, 41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bewier, Missouri**

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

(b) Address **918 Brooklyn, K. C. Mo.**

19. (a) **Jan. 26, 1941** (b) **H. M. Browne**
(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. **3040 Wabash Avenue, K.C. Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No**
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **25th**
year **1941** hour **6** minute **45 P. M.**

21. I hereby certify that I attended the deceased from **12-14-40** to **1-25-41**
that I last saw her alive on **1-25-41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Brown atrophy and dilatation of heart**

Due to **Senility**

Due to

Other conditions **Acute suppurative Bronchitis**

Acute pulmonary edema and congestion

Major findings:

Of operations

Of autopsy **See above**

Duration

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

23. Signature **Wm. R. Thom** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital, K. C. Mo.**

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

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.....

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, fact should be so stated above.