

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.

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: 3838 College
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether years, months or days)

In this community Six months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 047

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 3838 College
(If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years.

8. (a) PRINT FULL NAME Florence E. French

3. (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 Married

6. (b) Name of husband or wife Oscar A. French

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Feb. 2, 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>8</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER { 12. Name Edward Holmes

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

14. Maiden name Lillie Blatt

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

16. (a) Informant's own signature Jacques A. French

(b) Address 3838 College

17. (a) Burial (b) Date thereof 10/7/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill K.C.Mo.

18. (a) Signature of funeral director Gates Funeral Home

(b) Address 1901 North Blvd. C. Brown

19. (a) 10/6/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5
year 1941 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from 11 days
9, 1941, to October 5, 1941;
that I last saw her alive on October 4, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma left ovary Duration 1940

Due to _____

Due to _____

Other conditions metastatic
(Include pregnancy within 3 months of death)

Carcinoma of liver

Major findings: H90

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 Paul E. Willits (M. D. or other) _____
Address 612 Professional Bldg Date signed 10/6/41

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

Jimmy S. Buckshon

Licensed Embalmer No. *4092*

P. O. Address *Honolulu City, Hawaii*

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.