

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:  
1320 Harrison  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 5 years / \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson **049**  
(c) City or town Kansas City **3**  
(If outside city or town limits, write "RURAL") **8**  
(d) Street No. 1320 Harrison St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ **0**

3. (a) PRINT FULL NAME Mrs Dellie Hahn  
3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22nd  
year 1941 hour 1.55 P. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Oct. 5, 1941, to Oct. 22, 1941  
that I last saw her alive on Oct. 22, 1941  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
7. Birth date of deceased August 25, 1861  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration  
Myocardial Infarction **30 days**  
Due to Arterial Hypertension **30 days**  
Due to Cerebral Hemorrhage right Parietal Stroke **10 days**  
Other conditions (Include pregnancy within 3 months of death) 93E

8. AGE: Years 80 Months 1 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name No record

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

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Floria Moyer

(b) Address 1320 Harrison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/41 (Month) (Day) (Year)

(c) Place: burial or cremation Thomas E. Quirk Funeral Home (Specify type of place)

18. (a) Signature of funeral director 1320 Harrison St. (b) Address

19. (a) 10/24/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

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? \_\_\_\_\_

23. Signature M. A. Kiefer (M. D. or other) 1941

Address 1701 Jackson Ave Date signed Oct 23

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

048  
862

1941

**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.....  
*Thomas C. Jewik*  
.....  
Licensed Embalmer No..... *3775*  
.....  
P. O. Address..... *N.C. 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, fact should be so stated above.**