

FILED APR 1 1942

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: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community unk  
years, months or days)

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. 409 West 14th St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Addie Setterwhite

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced unk 9  
6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unk  
(Month) (Day) (Year)

8. AGE: Years 50 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation unk

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

MOTHER FATHER { 12. Name unk  
13. Birthplace unk (City, town, or county) (State or foreign country)  
14. Maiden name unk  
15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bright

(b) Address 604 W. 14th St.

17. (a) burial (b) Date thereof 5-17-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation People's Hall

18. (a) Signature of funeral director J. J. Johnson & Co.

(b) Address R.P. Ave.

19. (a) 2/13/42 (b) W. H. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th  
year 1942 hour 3 minute 50 P.M. or A.M.

21. I hereby certify that I attended the deceased from 3-3-42, 19\_\_\_\_, to 3-4-42, 19\_\_\_\_;  
that I last saw her alive on 3-4-42, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Auricular Fibrillation with cardiac failure

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy None

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 Dr. R. Johnson (M. D. or other)  
Address Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

4038

4238

201

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**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.....

working under my personal supervision.

*Embalmed by General Hospital*

Registered Apprentice No. ....

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.**