

Filed NOV 9 1942

Registration District No. 144

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kanas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1609 White Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 50 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kanas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1609 White
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME Katherine Cravens

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Unknown
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
About 70 hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Chandler
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Annis Prather
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Eddy E. Chandler

(b) Address Holt Missouri

17. (a) Burial (b) Date thereof Oct-19-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chandlers Cemetery

18. (a) Signature of funeral director F. S. Walton

(b) Address City

19. (a) 10-18-42 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 16
year 42 hour 9:15 minute P M.

21. I hereby certify that I attended the deceased from from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Brain aneurysm
Chronic hypertensive

Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy see form

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?

(Specify type of place) While at work..... (e) Means of injury.....
23. Signature M. M. Grove (M.D. or other)
Address City Date signed 10/16/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING 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..... *J. S. Walton*

Licensed Embalmer No. *2744*

P. O. Address..... *K. C. Mo*

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.