

FILED MAY 6 1943

Registration District No. **149**

Primary Registration District No. **1002**

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

**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 Mo. & 1 day  
(Specify whether)

In this community lifetime  
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. 3419 Troost Avenue  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

**3. (a) PRINT FULL NAME** Sarah Nicholson

**3. (b) If veteran,** 0 **name war**

**3. (c) Social Security No.** 486-10-6857

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month April day 25th  
1943 hour 8 minute 15 **A.M.** M.

**4. Sex** fe **5. Color or race** W

**6. (a) Single, widowed, married,** 2 **divorced, widow**

**6. (b) Name of husband or wife** Charles **6. (c) Age of husband or wife if** 29 **alive** 1877 **years**

**7. Birth date of deceased** May 29 1877  
(Month) (Day) (Year)

**21. I hereby certify that I attended the deceased from** 3-24-43 1943 to 4-25-43 1943  
that I last saw her alive on 4-25-43 1943  
and that death occurred on the date and hour stated above.

**8. AGE:** Years 65 Months 6 Days 26 If less than one day hr. min.

Immediate cause of death Exfoliative Dermatitis;  
Hypertensive heart disease

Due to 928

**9. Birthplace** K.C. Mo.  
(City, town, or county) (State or foreign country)

Other conditions 928  
(Include pregnancy within 3 months of death)

**10. Usual occupation** Starcher

Major findings: PHYSICIAN  
Of operations PHYSICIAN

**11. Industry or business** Country Club Laundry

**12. Name** Samuel F. Davis

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

**14. Maiden name** Mary M. Brown

**15. Birthplace** Little Rock Ark.  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Mr. Rose Ashley

**(b) Address** 4207 Bell

**17. (a)** Burial **(b) Date thereof** 4-24-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Greenlawn Cem.

**18. (a) Signature of funeral director** H. Legerman

**(b) Address** KE Mo.

**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 \_\_\_\_\_

**19. (a)** 4-22-43 **(b)** M. M. Brown **13. Signature** Drury R. Thom **(M. D. or other)** 0  
(Date received local registrar) (Registrar's signature) Address: Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

360

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.....

*Francis Walton*

Registered Apprentice No. *2744*

working under my personal supervision.

Signed.....

*J. K. Pugh*

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.