

REG. JUN 7 1943 49
Registration District No. _____

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:
6033 Rockhill Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **52 Years** (Specify whether)
years, months or days)

3. (a) PRINT FULL NAME **Mrs. Mable K. Ostrander**
3. (b) If veteran, name war **No**
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 **Mr. Charles A. Ostrander**
6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **November 3 1887**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	55	6	22	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

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

16. (a) Informant **Mr. Charles A. Ostrander**
(b) Address **6033 Rockhill Road**

17. (a) **Cremation** (b) Date thereof **5-27-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **D. W. Newcomer's Sons**

18. (a) Signature of funeral director **D. W. Newcomer's Sons**
(b) Address **1401 Brush Creek Blvd.**

19. (a) **5-27-43** (b) **M. M. Brown**
(Date received local report) (Registrar's signature)

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. **6033 Rockhill Road**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **25th**
year **1943** hour **2** minute **P.** M.
21. I hereby certify that I attended the deceased from **May 19 1943**
to **May 25 1943**
that I last saw her alive on **May 25 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Uterine Carcinoma**
Duration **8 mo.**

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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)
(c) Means of injury _____

23. Signature **Samuel S Schwartz** (M. D. or other) **D.O.**
Address **718 Chambers Bldg** Date signed **May 26**

9-5
718 Chambers Bldg.
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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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed: *K. C. Newcomer Jr*
Licensed Embalmer No. *310513*
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.