

FILED AUG 6 1943 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3168

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:
General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
(Specify whether
In this community 42 yrs.
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. 429 So. White
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dorothy Rumsby

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race Wh
6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Wm Peter Rumsby 6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Aug 9 1879
(Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 7 If less than one day _____ br. _____ min.

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

10. Usual occupation Widow

11. Industry or business _____

12. Name Wm Peter Rumsby

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

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

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

16. (a) Informant Wm P. Rumsby

(b) Address 429 So White

17. (a) Buried (b) Date thereof 7-19-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wm Jackson

18. (a) Signature of funeral director Wm G. L. Miller

(b) Address 1500 My

19. (a) 7-19-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th
year 1943 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 7 1943 to July 16 1943

that I last saw her alive on July 16 1943; and that death occurred on the date and hour stated above.

Immediate cause of death intercapsular fracture left hip

Due to accidental fall in home

Due to 186a

Other conditions (Include pregnancy within 3 months of death) 18

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence July 7, 1943, 12:30

(c) Where did injury occur MO (City or town) (County) (State)

(d) Did injury occur on or about home, on farm, in industrial place, in public place? In home

While at work _____ (Specify type of place)

Means of injury Fall

23. Signature Wm P. Rumsby (M. D. or other) MD

Address General Hosp. Date signed _____

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

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed C. H. Wise
Licensed Embalmer No. 25-70
P. O. Address 15 @ 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.