

FILED JAN 5 1944

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5399

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: ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6-DAYS
In this community 12 YEARS (Specify whether 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. 4134 TROOST AVENUE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS IDA HUDSON EDWARDS

3. (b) If veteran, name war NO 3. (c) Social Security No. 496-16-9793

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MR. HOWARD D. EDWARDS
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased NOVEMBER - 10 - 1908
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
35 1 7 hr. _____ min.

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

10. Usual occupation INSPECTRESS

11. Industry or business REMINGTON-ARMS

MOTHER FATHER { 12. Name CHESTER A. HUDSON
13. Birthplace VERMILION COUNTY ILLINOIS
(City, town, or county) (State or foreign country)
14. Maiden name SADIE COLLINS
15. Birthplace BARBER COUNTY KANSAS
(City, town, or county) (State or foreign country)

16. (a) Informant MR. HOWARD D. EDWARDS
(b) Address 4134 TROOST AVENUE

17. (a) BURIAL (b) Date thereof DEC 20 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PARK CEM.

18. (a) Signature of funeral director D. H. Newcomer's son
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 12-20-43 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 17TH
year 1943 hour 9 minute 20 P. M.
21. I hereby certify that I attended the deceased from Dec 27
1943 to Dec 9 1943
that I last saw him alive on Dec 9 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial failure
Due to mesenteric thrombosis
Due to 9911
Other conditions (Include pregnancy within 3 months of death) _____

Duration 2 days
2 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: Intestinal obstruction
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) (e) Means of injury _____
23. Signature John T. Shriver (M. D. or other) MD.
Address 1402 1/2 2nd St Date signed 12-17-43

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

KEMO

1400a Bryant Bldg
2.6

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 Emile M. Calhoun
Licensed Embalmer No. 3506
P. O. Address K. O. M.

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.