

FILED FEB 6 1945

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:  
1315 Charlotte  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community about 20 yrs.  
years, months or days (Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1315 Charlotte  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fern Abby Selby  
(b) If veteran, name war no  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 14  
year 1945 hour 8:10 minute 4 M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him Coroner \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above

4. Sex Fe. 5. Color or race W.  
6. (a) Single, widowed, married, divorced M.  
(b) Name of husband or wife Harry L. Selby  
(c) Age of husband or wife if alive 56 years

Immediate cause of death \_\_\_\_\_  
Coronary sclerosis  
arterio sclerosis

7. Birth date of deceased: Unknown  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
aprox. 47 hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations Histology & Inspection  
Of autopsy aut

9. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

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

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)

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 Jean Walker (M. D. or other) Coroner  
Address 1424 Profan pl. Date signed 1-14-45

16. (a) Informant Jackson County Coroners Office  
(b) Address K. C. MO.  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/45  
(Month) (Day) (Year)  
(c) Place: burial or cremation Greenlawn Cemetery  
18. (a) Signature of funeral director H. Tigeramn & Sons  
(b) Address K. C. MO.  
19. (a) 1-18-45 (Data received local registrar) (b) N. E. Brown (Registrar's signature)

**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. *R. 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.**