

FILED MAR 7 1945

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2919 Wayne Ave. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community 50 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City Mo. 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 2919 Wayne Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Hannah B. UMBROOK.

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, Widow 2
6. (b) Name of husband or wife Edward Umbrook 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased January 3rd, 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 18 If less than one day hr. min.

9. Birthplace Decatur Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Michael J. Begley
13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Galvin
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Irene Carroll Wimmer
(b) Address 2919 Wayne Ave.

17. (a) Burial (b) Date thereof 2/23/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Melody McGilley
(b) Address Kansas City Mo.

19. (a) 2-23-45 (b) N. E. Brown
(Data received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month February day 21st
year 1945 hour 9 minute 50 A. M.

21. I hereby certify that I attended the deceased from Oct 4th to Feb 21, 1945
that I last saw her alive on Feb 18, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema
Due to Cancer lung
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations 47 1/2
Of autopsy _____

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?

(Specify type of place) While at work? (c) Means of injury _____
23. Signature Lester J. Wilson (M. D. or other)
Address Phys. Med Bldg Date signed _____

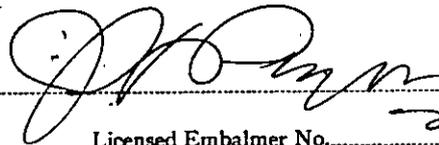
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. ~~H~~aster Wilson
Plaza Med. Bldg.
Lo. 1533

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



Licensed Embalmer No.....
2999

P. O. Address.....
KC

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5359
Registrar's No. 895

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

3. (a) PRINT FULL NAME Hannah B Umbrook

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan 3 1860
(Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-23-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 Day 1 Year 1945 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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) (e) Means of injury _____

23. Signature Hester J. Wilson (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

5359.