

**FILED** JAN 21 1946

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

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 #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
In this community 20 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. 3639 Paseo  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Easter Clinkscale

3. (b) If veteran, name war None  
3. (c) Social Security No. 499 Art 6-3887

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Mar. 1  
6. (b) Name of husband or wife Herbert Clinkscale 6. (c) Age of husband or wife if alive 36 years  
7. Birth date of deceased November 30 1903 (Month) (Day) (Year)

8. AGE: Years 42 Months 0 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Dish washer

11. Industry or business None

MOTHER FATHER { 12. Name O. B. Mc Kyer  
13. Birthplace Louisiana (City, town, or county) (State or foreign country)  
14. Maiden name Annis Hadden  
15. Birthplace Louisiana (City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian  
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 12/29/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Robbins Bros  
(b) Address 1729 N. 1st

19. (a) 12-28-45 (b) Etheldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 25, year 1945 hour 2: minute 30 A. M.

21. I hereby certify that I attended the deceased from December 22, 1945, to December 25, 1945; that I last saw her alive on December 25, 1945; and that death occurred on the date and hour stated above.  
Immediate cause of death Diabetic Acidosis

Due to Diabetes Mellitus

Due to \_\_\_\_\_  
Other conditions Urinary Retention  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations W  
Of autopsy \_\_\_\_\_  
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 W  
23. Signature J. O. Durand (M.D. or other)  
Address General Hospital #2 Date signed 12/26/45

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

100246

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**