

FILED MAR 2 1948

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 784

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 #1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether
In this community 43 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 5807 E. 9th 8
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Gertrude Shawen

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 Joseph A. Shawen 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased 8 (Month) 16 (Day) 1899 (Year)

8. AGE: Years 66 Months 5 Days 28 If less than one day hr. min.

9. Birthplace Benton Co. Ark (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Wm S. Conroy
13. Birthplace Benton Co. Ark (City, town, or county) (State or foreign country)
14. Maiden name Sarah Jane Taylor
15. Birthplace Ida (City, town, or county) (State or foreign country)

16. (a) Informant Miss Dorothy Richardson

(b) Address 5807 E. 9th St. K.C., Mo

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/16/46 (Month) (Day) (Year)

(c) Place: burial or cremation Wm Washington

18. (a) Signature of funeral director John P. Smith

(b) Address K.C. Mo

19. (a) 2-15-46 (Date received local registrar) (b) Heraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14th
year 1946 hour 5:00 minute 20 A.M. M.

21. I hereby certify that I attended the deceased from Feb. 13, 1946 to February 14, 1946
that I last saw her alive on February 14, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic acidosis with CVA, cerebrovascular accident

Due to _____

Due to _____

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

Major findings: 61
Of operations _____

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? _____ (e) Means of injury 0

23. Signature Clark A. Seelyard (M.D. or other)

Address Gen Hosp #1 Date signed _____

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

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

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.....

John P. Sheil

Licensed Embalmer No. *03625*

P. O. Address *K.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.