

FILED APR 17 1946
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State File No. _____
Registrar's No. 1624

Registration District No. _____ Primary Registration District No. 1002

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 No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days) 35 years

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. 525 No. College
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 4
year 1946 hour 10 minute 55 A.M.

4. Sex fe 5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Bob Newhouse
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased Feb 10 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 30, 1946, to April 4, 1946
that I last saw her alive on April 4, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident

8. AGE: Years Months Days If less than one day
63 1 25 24 hr. min.

Duration _____

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

Due to _____

10. Usual occupation Housewife

Due to _____

11. Industry or business _____

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

MOTHER FATHER { 12. Name Ben Yount
13. Birthplace Terre Haute Ind.
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

14. Maiden name unknown
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

Of autopsy None

16. (a) Informant Bob Newhouse
(b) Address 525 N College

Physician _____
Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof 4-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

18. (a) Signature of funeral director H. T. ...
(b) Address K.R. ...

(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? _____

19. (a) 4-5-46 (b) St. ...
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature W. W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 4-5-46

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

As Embalmer

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.....

Francis Walton....., Registered Apprentice No. *2744*
working under my personal supervision.

Signed *J. H. [Signature]*.....
Licensed Embalmer No. *2744*
P. O. Address *K-O. N.W.*

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.