

FILED AUG 19 1946

Registration District No. 149

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:
605 E. 11th
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 6 years
years, months or days)

3. (a) PRINT FULL NAME Cynthia Rains

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Wid. 2

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

7. Birth date of deceased Dec. 25 1852
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>93</u> | <u>7</u> | <u>21</u> | hr. _____ min. |

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

10. Usual occupation Invalid for years

11. Industry or business _____

MOTHER FATHER {
 12. Name Unknown
 13. Birthplace _____ 9
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace _____ 9
(City, town, or county) (State or foreign country)

16. (a) Informant Claud Roberts

(b) Address 605 E. 11th

17. (a) Burial (b) Date thereof Aug. 7, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C.H. Blackman & Son, Inc

(b) Address 2825 Independence Blvd.

19. (a) 8-6-46 (b) Straliding Holme
(Date received local registrar) (Registrar's signature)

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. 605 E. 11th 8
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 6
 year 1946 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from Feb. 4, 1946 to August 6, 1946
 that I last saw him alive on August 3, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death: myocardial, chronic few mos
hypertension, chronic few mos

Due to _____

Due to _____

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

Major findings: _____
 Of operations: _____
 Of autopsy: _____

Duration

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 B. Atcherson (M. D. or other) 0
 Address 522 Professional Date signed Aug 6, 46

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

