

No. 2
-12-45
-17-39
X47070

FILED NOV 12 1946
Registration District No. 177

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 25 YEARS
years, months or days (Specify whether)

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. 905 Tracy 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26th
year 1946 hour 4 minute 40 A.M.
21. I hereby certify that I attended the deceased from
10-25-46, 19, to 10-26-46, 19;
that I last saw her alive on 10-26-46
and that death occurred on the date and hour stated above.
Immediate cause of death Heart failure Duration _____

3. (a) PRINT NAME MATILDA WERNER
FULL NAME Matilda Werner
3. (b) If veteran, name war No
3. (c) Social Security No. 17 011 E

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife EDWARD D WERNER
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased. OCT 18 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day,
70 0 8 hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER { 12. Name ABRAM RENNICK
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name ADELINE UNKNOWN
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant Edward D Werner
(b) Address 905 Tracy

17. (a) CREMATION (b) Date thereof OCT-28-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation D.W. NEWCOMERS SONS

18. (a) Signature of funeral director O.H. Newcomer Sine
(b) Address 1401 Brush Creek Bluff, S.C. 4 Mo.

19. (a) 10-28-46 (b) Sheldine Helms
(Date received local registrar) (Registrar's signature)

Due to Arterio Sclerotic
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 93rd
Of operations _____
Of autopsy See above

22. If death was due to external causes, fill in the following:
(c) 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? 0

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Wm W. Hard (M. D. or other) md
Address Ed. Dir. K.C. Gen. Hospital
Date signed 10-26-46

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 Emile M. Calhoun

Licensed Embalmer No. 3506

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.