

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City**
 (c) Name of hospital or institution: **5914 Charlotte 4 Conv. Home**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 months**
 In this community **26 years**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Kansas** (b) County **997**
 (c) City or town **Frankfort** **14**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **-** **0**
 (If rural, give location) **2**
 (e) Citizen of foreign country? **no.** (Yes or No)
 If yes, name country **X**

3. (a) PRINT FULL NAME **Mrs. Annette Wright**
3. (b) If veteran, name war **no.** **3. (c) Social Security No.** **no.**
4. Sex **female** **5. Color or race** **white** **6. (a) Single, widowed, married, divorced** **widowed**
6. (b) Name of husband or wife **Albert Wright** **6. (c) Age of husband or wife if alive** **dec.** years
7. Birth date of deceased **May 17 1862**
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **November** day **19**
 year **1946** hour **8:30** minute **P.** M.
21. I hereby certify that I attended the deceased from **Nov 15 1946 to Nov 19 1946**
 that I last saw him alive on **Nov 19 1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral Thrombosis** **1 week**
 Due to **arteriosclerosis** **10 yrs**
 Due to **Chronic Myocarditis** **10 yrs**
 Other conditions: **Chronic Myocarditis**
 (Include pregnancy within 3 months of death)

8. AGE: Years **84** Months **6** Days **2** If less than one day
 hr. min.
9. Birthplace **Canada**
 (City, town, or county) (State or foreign country)
10. Usual occupation **at home,**
11. Industry or business **X**
MOTHER FATHER { **12. Name** **George Stoliker** **1**
13. Birthplace **Massachusetts** (State or foreign country)
14. Maiden name **Cecelia**
15. Birthplace **Canada** (State or foreign country)

Major findings:
 Of operations: **93D**
 Of autopsy: **93D**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Delia A. Judy,**
(b) Address **5914 Charlotte, Kansas City, Mo.**
17. (a) Cremation **(b) Date thereof** **10-22-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood Cemetery**
18. (a) Signature of funeral director **Stine & McClure**
(b) Address **3235 Gillham Plaza, K. C., Mo.**
19. (a) 11-20-46 **(b) Thelma Holmes**
 (Date received local registrar) (Registrar's signature)

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 **G**
23. Signature **J. Sheldon** (M. D. or other)
Address **24th Street** **Date signed** **20 Nov 46**

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

36074

Dr. John Sheldon

Van Phillips

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

[Signature]
.....
Licensed Embalmer No. 1415-

P. O. Address 17, E. 17th

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.