

S. No. 2
 4-12-45
 7. 5-17-39
 I X47070

FILED AUG 19 1947

Registration District No. 149

Primary Registration District No. 1002

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

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. 2 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 DAYS
 (Specify whether in this community 30 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. 1419 LYNN 8
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MARY ROSS
 3. (b) If veteran, name war NO
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month AUGUST day 5, year 1947 hour 7: minute 20 P.M.
 21. I hereby certify that I attended the deceased from JULY 30, 1947 to AUGUST 5, 1947;
 that I last saw h. ER alive on AUGUST 5, 1947;
 and that death occurred on the date and hour stated above.

4. Sex FEMALE 3 5. Color or race NEGRO
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife unk. 6. (c) Age of husband or wife if alive Deceased years
 7. Birth date of deceased OCTOBER 5, 1900
 (Month) (Day) (Year)

Immediate cause of death CHRONIC HYPERTENSIVE HEART DISEASE WITH DECOMPENSATION Duration _____

8. AGE: Years 46 Months 10 Days 0
 If less than one day _____ hr. _____ min.

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

9. Birthplace BUTLER MISSOURI 0
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

12. Name WILLIAM HUDSON

13. Birthplace UNK. MO. MISSOURI
 (City, town, or county) (State or foreign country)

14. Maiden name FANNIE ESTES

15. Birthplace UNK. KY. KENTUCKY
 (City, town, or county) (State or foreign country)

16. (a) Informant WILLA B. ROBINSON (SISTER)

(b) Address 621 N. HOCKER; INDEPENDENCE, MO.

17. (a) Burial (b) Date thereof Aug. 8, 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodland Cen. Indef, Mo.

18. (a) Signature of funeral director Lab. Davis

(b) Address 1575 Troost Ave.

19. (a) 8-8-47 (b) Sheldine Holmes
 (Date received local registrar) (Registrar's signature)

Major findings: 932
 Of operations _____
 Of autopsy _____

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

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? _____

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

23. Signature Frank Edin (M. D. or other) M.D.

Address GENERAL HOSPITAL NO. 2 **Date signed** 8/6/47

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.....

Ch. Davis

Licensed Embalmer No.....

4417

P. O. Address.....

R. C. am

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.