

FILED NOV 8 1947 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4579

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution: St. Lukes Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution 6 mos
In this community 6 mos
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County 999
(c) City or town Fort Scott Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. H 19 Jackson St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MARGARET McLean

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive years

7. Birth date of deceased November 6, 1890
(Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 11 24 hr. min.
If less than one day

9. Birthplace Fort Scott Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation School Teacher

11. Industry or business _____

12. Name Neil Mc Sean

13. Birthplace Scotland
(City, town, or county) (State or foreign country)

14. Maiden name Janet Robinson

15. Birthplace Scotland
(City, town, or county) (State or foreign country)

16. (a) Informant Lillian May Mc Sean

(b) Address Fort Scott Kansas

17. (a) Removal (b) Date thereof 10/31/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fort Scott Kansas

18. (a) Signature of funeral director Gene M. Chue

(b) Address Kansas City Mo

19. (a) 11-1-47 (b) Gene M. Chue
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30
year 1947 hour 10 minute 34 P. M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him Pathologist alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Diffuse Peritonitis
Due to Rupture of appendix
Due to Carcinoma of Breast metastatic to Appendix
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 50
Of autopsy Same

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) _____ (Specify means of injury) _____
23. Signature G. C. W. [unclear] (M. D. or other) _____
Address St. Lukes Hospital Date signed 3/20/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

J. Blair Shippard

Licensed Embalmer No.:

4179

P. O. Address.....

H. C. Ford

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.