

FILED JUN 17 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

2031

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Pratt Home for Elderly People
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether
 In this community 10 years
years, months or days)

3. (a) PRINT FULL NAME MRS. I. D. A. MAYLAND

8. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife Robert 6. (c) Age of husband or wife if alive ✓ years
 7. Birth date of deceased Oct 30 1856
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 15 If less than one day
hr. min.

9. Birthplace Dalton Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Richard H. Richardson

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

14. Maiden name Myra Swann

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

16. (a) Informant's own signature William H. Kelly

(b) Address 3518 Harrison

17. (a) removal (b) Date thereof 5-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gillian Mo

18. (a) Signature of funeral director Howard J. Koe

(b) Address 6900 Pratt

19. (a) May 16, 1940 (b) M. M. Crome
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3518 Harrison
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
 year 1940 hour 10 30 minute _____ M.

21. I hereby certify that I attended the deceased from 5-7-40
~~5-15~~ to 5-15-40
 that I last saw her alive on 5-15-40
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy sudden
 Duration _____

Due to sanitary 82nd

Due to _____

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

Major findings: _____
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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 W. H. Kelly (M. D. or other) _____

Address 8140 Prof Bldg Date signed 5-16

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. 2748
working under my personal supervision.

Signed Howard J. Rol

Licensed Embalmer No. 2748

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, above space should be left blank.