

FILED JAN 7 1947  
149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002

**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:  
St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week  
(Specify whether)

In this community 45 Years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Kansas (b) County Shawnee

(c) City or town Shawnee  
(If outside city or town limits, write "RURAL")

(d) Street No. 224 Johnson  
(If rural, give location)

(e) Citizen of foreign country? Yes no (Yes or No) no  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Charles W. Winterbottom

3. (b) If veteran, name war No

3. (c) Social Security No. No

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 21  
year 1946 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec 12 - 46  
1946 to Dec 21 - 46  
that I last saw him alive on Dec 21 - 1946  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Wh.

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Flora

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan. II 1879  
(Month) (Day) (Year)

Immediate cause of death Pulmonary Embolism

Due to Post-operative Trans-Urethral Prostatic Resection

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**8. AGE:**

Years	Months	Days	If less than one day
<u>67</u>	<u>II</u>	<u>IO</u>	_____ hr. _____ min.

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

10. Usual occupation Rail Road

**MOTHER FATHER**

11. Industry or business \_\_\_\_\_

12. Name James S. Winterbottom

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

14. Maiden name Ella Hamilton

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

Major findings: Prostatic Hypertrophy

Of operations \_\_\_\_\_

Of autopsy as above

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

16. (a) Informant Mr. Clyde Winterbottom

(b) Address 7733 East 55th. St

17. (a) Burial (b) Date thereof 12/24/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem

18. (a) Signature of funeral director Wornall Funeral Home

(b) Address 7406 Wornall Rd.

19. (a) 12-23-46 (b) Alfredine 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 \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address 1019 Pine Blvd Date signed 12-24-46

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

30738

*Edwards*  
*3816-El*

**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 *Howard G. Ral*  
Licensed Embalmer No. *2748*  
P.O. Address: *H 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.**