

RECORDED MAY 9 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13550

Do not use this space.

1. PLACE OF DEATH *Mercy Hospital*

(a) County *Jackson* Registration District No. *399*

(b) Township *Kaw* Primary Registration District No. *1002*

(c) City *Kansas City* (d) Street No. *Mercy Hospital* Registered No. *1530*

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Betha Willis (Bertha Joe Willis,) correct. 4.20*

(a) Residence, No. *1514 Holmes* St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Child*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *-*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 1st, 1937*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	-	10	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. *Child*

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *K.C., Mo.*

FATHER

13. NAME *James Willis*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Arkansas*

MOTHER

15. MAIDEN NAME *Elva Hood*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Oklahoma*

17. INFORMANT *Jas. H. Willis 1514 Holmes St. Kansas City, Missouri.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Memorial Park Cem* DATE *Apr 9th 1938*

19. FUNERAL DIRECTOR (ADDRESS) *Mrs. C. L. Gardner 918 Broadway Ave*

20. FILED *Apr 8 1938* M. D. *Ortome* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-6 1938*

22. I HEREBY CERTIFY, That I attended deceased from *3-28 1938*, to *4-6 1938*, 19*38*

I last saw h.c.r. alive on *4-6 1938*. Death is said to have occurred on the date stated above, at *9:05 P.* m.

The principal cause of death and related causes of importance were as follows:

Tuberculous meningitis

Date of onset *3-21-38*

Other contributory causes of importance:

Otitis media - bilateral

Name of operation *none* Date of *-*

What test confirmed diagnosis? *Smear* Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *-* Date of injury *-*, 19*-*

Where did injury occur? *-* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *-*

Nature of injury *-*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify *N. B. Sorkinberg* M. D.

(Signed) *S. H. Miller* (Address) *St. Louis 1 to print*

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
.....L. E.....
No.....or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)