

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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4744

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:  
1107 E. Linwood 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 da.  
(Specify whether  
 In this community 10 yrs.  
years, months or days)

3. (a) PRINT FULL NAME ZELLA H. WILLIAMS 458

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Thomas D. 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased Nov. 10- 1882  
(Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 3 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Nolbert

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

14. Maiden name SALLY SCOTT

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

16. (a) Informant's own signature Thomas D. Williams

(b) Address 1107 E. Linwood

17. (a) Burial (b) Date thereof Dec. 15th  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hill

18. (a) Signature of funeral director A. F. Mayberry

(b) Address 2515 E. Lincoln Blvd

19. (a) Dec. 14, 1939 (b) M. M. Grome  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1107 E. Linwood  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 13th day  
 year 1939 hour 11 minute 55 M.

21. I hereby certify that I attended the deceased from Nov 15  
1939, to Dec 13, 1939  
 that I last saw him w alive on 12/13-, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to 1070

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

Other conditions Ac Bronchitis  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations ✓

Of autopsy none

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

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? 1

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. M. Cavanaugh (M. D. or other)

Address 615 Agyle St Date signed 12/14-39

**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

*Ray E. Snow*

Licensed Embalmer No. 2560

P. O. Address 1807 E 29th

**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.**