

FILED FEB 26 1940  
399

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 235

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:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days) 10 years

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. 708 East 8th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15th  
year 1940 hour 9 minute 00 A. M.

21. I hereby certify that I attended the deceased from 1-8-1940, 19\_\_\_\_, to 1-15-40, 19\_\_\_\_;  
that I last saw her alive on 1-15-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Left pleural empyema</u>	
<u>Acute pericarditis</u>	
Due to <u>Lobar pneumonia</u>	
Due to <u>100</u>	
Other conditions <u>Pulmonary Edema</u>	
(Include pregnancy within 3 months of death)	

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy See above

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 P. DeMara M.D. (M. D. or other)  
Address Supt. K.C. Gen. Hospital Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Lillie Dell Wilson 425  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Joe Wilson 6. (c) Age of husband or wife if alive 34 years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 22 Months X Days X If less than one day \_\_\_\_\_ min.

9. Birthplace Nacogdoches Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name unknown  
13. Birthplace unknown (City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joe Wilson  
(b) Address 708 East 8th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16, 1940 (Month) (Day) (Year)  
(c) Place: burial or cremation Nacogdoches Texas

18. (a) Signature of funeral director N. K. ...  
(b) Address 2335 Prospect St. No. 708

19. (a) Jan. 17, 1940 (Date received local registrar) (b) H. H. ... (Registrar's signature)

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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by 2744  
Francis Walton, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Francis Walton  
J. H. Kuehman  
Licensed Embalmer No. 2744  
P. O. Address H. E. 2nd.

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.