

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

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**

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: **General Hospital #2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5-17-40-6-9-40**  
**7 months** (Specify whether years, months or days)  
In this community \_\_\_\_\_

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. **1602 Paseo, 3rd fl.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Elaine Williams**  
3. (b) If veteran, name war **None**  
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **6** day **9**  
year **40** hour **8** minute **P.** M.

4. Sex **Female** 5. Color or race **Negro**  
6. (a) Single, widowed, married, divorced **Single**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: **10** **2** **1939**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **5-17-** **19 40** to **6-9-** **19 40**  
that I last saw h **er** alive on **6-9-** **19 40**  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
**8** **7** hr. \_\_\_\_\_ min.

Immediate cause of death **Bronchial Pneumonia.**  
Due to **Tuberculous Meningitis**  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace **Kansas City** **Mo.**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **none**  
11. Industry or business \_\_\_\_\_  
12. Name **Herschel Williams**  
13. Birthplace **Mo.**  
14. Maiden name **Greta Mackey**  
15. Birthplace **Mo.**  
(City, town, or county) (State or foreign country)

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) Means of injury \_\_\_\_\_

16. (a) Informant's own signature **Record Clerk**  
(b) Address **General Hospital #2**  
17. (a) **Burial** (b) Date thereof **6/12/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Highland**  
18. (a) Signature of funeral director **Watkins Bros**  
(b) Address **1727 Lydia**  
19. (a) **June 12, 1940** (b) **M. M. Crowe**  
(Date received local registrar) (Registrar's signature)

23. Signature **J. O. Thorne** (M. D. or other)  
Address **Gen. Hosp. #2** Date signed **6-11-**

1 X1931

**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

*R. M. Adams*

Licensed Embalmer No. *4116*

P. O. Address *1729 Lydia, K.S. 7716*

**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.**