

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41329**
Registrar's No. **4722**

Registration District No. **399** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K. C. M. B. Hospital.
(d) Length of stay: In hospital or institution 2 mos. 16 days.
In this community Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City
(d) Street No. 2433 Flora
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Willis, FANNIE (Fannie Willis)
(b) If veteran, name war None
(c) Social Security No. None.

20. DATE OF DEATH: Month Dec. day 7
year 1940 hour 6 minute 55 P.M.

4. Sex female 5. Color or race negro
6. (b) Name of husband or wife Walter Willis
7. Birth date of deceased Oct 15 1873

21. I hereby certify that I attended the deceased from Sept. 21, 1940, to Dec. 7, 1940;
that I last saw her alive on Dec. 7, 1940,
and that death occurred on the date and hour stated above.

8. AGE: Years 67 Months 1 Days 22
If less than one day _____ hr. _____ min.

Immediate cause of death Pulmonary Tbc
Due to 23
Due to _____

9. Birthplace Kentucky
10. Usual occupation Lanierdress

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER
11. Industry or business _____
12. Name Henry, John
13. Birthplace Kentucky
14. Maiden name Bowen, Agnes
15. Birthplace Kentucky

PHYSICIAN _____
Underline the cause to which death should be charged statistically _____

16. (a) Informant's own signature K.C. Municipal Hosp
(b) Address Leeds 5 Tox
17. (a) burial (b) Date thereof 12/13/40
(c) Place: burial or cremations Highland Cem.
18. (a) Signature of funeral director Walter Willis
(b) Address 1729 Lydia
19. (a) 12-11-40 (b) M. M. Crowe

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
28. Signature Adelbert W. Supt (M. D. or other) _____
Address K.C. M. B. Hospital Date signed _____

WRITE PLAINLY—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.

11-11951

(FILL IN)

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 _____

Irma Jerome Mander

Licensed Embalmer No. _____

3994

P. O. Address _____

1120 E. 23rd St

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.