

FILED OCT 5 1942 / 49
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH: **Jackson**

(a) County.....

(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** **D**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Mo. & 12 days**
(Specify whether years, months or days) **35 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

(c) City or town **Kendon, Missouri**
(If outside city or town limits, write "RURAL")

(d) Street No.....
(If rural, give location)

(e) Citizen of foreign country? **Unknown** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **JAMES M. WILLIS**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **unk**

4. Sex **Male** **6** 5. Color or race **W.**

6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **Sept. 1st 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

69 **18** hr. min.

9. Birthplace **Georgia** **1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business.....

MOTHER FATHER { 12. Name **James Willis** **1**

13. Birthplace **Georgia** **1**
(City, town, or county) (State or foreign country)

14. Maiden name **Beatrice Unknown**

15. Birthplace **Georgia** **1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **K.C. General Hospital**

17. (a) **Anatomical** (b) Date thereof **9 23 42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Western Dental College**

18. (a) Signature of funeral director **Weilert Funeral Home**

(b) Address **2332 Monitor Place: K.C. Mo.**

19. (a) **9/23/42** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **19th**
year **1942** hour **6** minute **30** A.M.M.

21. I hereby certify that I attended the deceased from **8-7-42** 19... to **9-19-42** 19...
that I last saw him alive on **9-19-42** 19...
and that death occurred on the date and hour stated above.

IMMEDIATE CAUSE OF DEATH
CARCINOMA OF LARYNX

Due to **47a**

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....
None

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?.....

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

23. Signature **Dr. R. Thom** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital, K.C.** Date signed.....

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

Blaine O. Walker

Licensed Embalmer No.

4075

P. O. Address

2332 Montclair Pl.
C.C.M.

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, fact should be so stated above.