

FILED DEC 3 1943

Registration District No. 149

Primary Registration District No. 1002

4960

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital No. 2
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 11-8-43-11-17-43
(Specify whether
In this community 20 yr.
years, months or days)

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. 1516 Olive
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME MARGARET WINTERS

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married. Divorced widow
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased. April 15 1867
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 2
If less than one day..... hr. min.

9. Birthplace Houston Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation unemployed

11. Industry or business.....

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

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2
17. (a) Funeral (b) Date thereof 11/24/43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cem
18. (a) Signature of funeral director Atkins Bros
(b) Address 1729 Lyda
19. (a) 11-24-43 (b) D. E. Brown
(Date received local report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17
year 1943 hour 2:40 minute P. M.

21. I hereby certify that I attended the deceased from November 8 1943 to November 17 1943
that I last saw her alive on November 17 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Cerebral Sclerosis

Due to 63a1

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

Major findings:
Of operations.....
Of autopsy Same as above.

Duration
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?
While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signatures D. E. Brown (If P. or other)
Address Gen. Hosp #2-600 E. 22 Date signed 11-19-43

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

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed.....
Jerome Manlove

Licensed Embalmer No.....
3994

P. O. Address.....
2503 Highland

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.