

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

2  
-13  
-39  
37823

FILED MAY 25 1944

Registration District No. 149

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: K. C. Convalescent Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks  
In this community 4 years, months or days

3. (a) PRINT FULL NAME NETTIE E. TILLOTSON

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

4. Sex Fe. 5. Color or race White 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 Jan. 9, 1882  
(Month) (Day) (Year)

8. AGE: Years 62 Months 4 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Chariton Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Nurse

11. Industry or business St. Vincent's Hospital

MOYER FATHER

12. Name Martin Tillotson

13. Birthplace Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Susan Hurt

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Hugh Pinnell  
(b) Address 3945 St. John

17. (a) Removal (b) Date thereof May 17, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salisbury, Mo.

18. (a) Signature of funeral director C. H. Blackman & Son, Inc.  
(b) Address Kansas City, Mo.

19. (a) 5-17-44 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 21  
(c) City or town Salisbury (If outside city or town limits, write "RURAL") 2  
(d) Street No. Missouri (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No) 1  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16  
year 1944 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from 4-20-44  
to 5-16-44  
that I last saw her alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Due to Arteriosclerosis

Due to \_\_\_\_\_

Other conditions 97  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of Injury \_\_\_\_\_

23. Signature Mary Jane (M. D. or other) \_\_\_\_\_  
Address 3945 St. John Date 5-18-44

Dr. Lammington

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 W.D. Blackman

Licensed Embalmer No. 3639

P. O. Address K.C. Mo

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.