

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

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:  
Home- 1526 Cypress  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Six Years (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Lillian Stilts  
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife George Stilts 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Feb 28th, 1888  
(Month) (Day) (Year)

8. AGE: Years 56 Months 3 Days 16 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant George Stilts

(b) Address 1526 Cypress Ave.

17. (a) Burial (b) Date thereof 6/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St

19. (a) 6-15-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 1526 Cypress Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th  
year 1944 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from May 11 -  
1944 to June 14, 1944  
that I last saw him alive on June 13 -, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 24 hours

Due to extension of bronch  
intestinal

Due to 4/6

Other conditions \_\_\_\_\_  
(Include pregnancy, within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations W R Foster

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature W R Foster (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed June 14

**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.....

Licensed Embalmer No. ....

P. O. Address.....

**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.**