

**FILED** MAR 18 1946

Registration District No. 177

Primary Registration District No. 1002

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

8362

**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: General Hospital #20  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Alpha Hamilton  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. no

4. Sex Female 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife unknown  
 6. (c) Age of husband or wife if alive 27 years  
 7. Birth date of deceased December 27, 1893  
(Month) (Day) (Year)

**8. AGE:**  
 Years 52 Months 2 Days 4  
 If less than one day hr. min.

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

10. Usual occupation House Work

11. Industry or business at home

**MOTHER, FATHER**  
 12. Name unknown  
 13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian  
 (b) Address General Hospital #2

17. (a) Burial (b) Date thereof 3-7-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Knollgreen H. C. Ex.

18. (a) Signature of funeral director Mrs. J. H. Jones  
 (b) Address 440 State Ave. C.P.C. Bldg.  
 19. (a) 3-7-46 (b) Seraldine Holmes  
(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")  
 (d) Street No. 1127 Independence Ave. 8  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No) 0  
 If yes, name country.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 1, year 1946 hour 8: minute 50 A. M.

21. I hereby certify that I attended the deceased from February 28, 19 46 to March 1, 19 46  
 that I last saw her alive on March 1, 19 46  
 and that death occurred on the date and hour stated above.

Immediate cause of death Suppurative Cholangitis  
Primary carcinoma of the gall bladder  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 466  
 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 E. D. Kelly (M. D. or other)  
 Address General Hospital #2 Date signed 3/1/46

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**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: *Eugene English*  
Licensed Embalmer No. *44803*  
P. O. Address *4970 State Ave. W.*

**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.**