

S. No. 2
M-5-43
7. 5-17-39
P I X36671

FILED AUG 14 1948

Registration District No. **1002** 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:
GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 days**
(Specify whether years, months or days)

In this community **27 yrs.**

3. (a) PRINT FULL NAME **BEATRICE WOODS**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **710**

4. Sex **FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**

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

7. Birth date of deceased **MAY 7. 1898**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	48	2	23	hr. min.

9. Birthplace **PARIS TEXAS**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business

MOTHER FATHER

12. Name **JOHN CORLAY**

13. Birthplace **CLARKSVILLE TEXAS**
(City, town, or county) (State or foreign country)

14. Maiden name **ADA RHODES**

15. Birthplace **PARIS TEXAS**
(City, town, or county) (State or foreign country)

16. (a) Informant **LENA WOODS (Sister)**

(b) Address **2013 Park**

17. (a) **Burial** (b) Date thereof **8-2-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **General**

18. (a) Signature of funeral director **[Signature]**

(b) Address **2000 E. 12th St. Mo.**

19. (a) **8-2-46** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

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. **2517 PARK**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **30**, year **1946** hour **11**: minute **00** A. M.

21. I hereby certify that I attended the deceased from **JULY 20**, 19 **46** to **JULY 30**, 19 **46**; that I last saw **or** alive on **JULY 30**, 19 **46** and that death occurred on the date and hour stated above.

Immediate cause of death **TERMINAL BRONCHO-PNEUMONIA**

HYPERTENSIVE HEART DISEASE WITH GENERALIZED ARTERIO-SCLEROSIS

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **93 d**

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)

(e) Manner of injury

23. Signature **[Signature]** (M. D. or other)

Address **GENERAL HOSPITAL NO. 2** Date signed **7/31/46**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

A. T. Moore

Licensed Embalmer No.....

946

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.