

S. No. 2
M-12-45
v. 5-17-39
X47070

9450

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1223

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:
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

In this community 4 YRS.
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. 562 FOREST
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME KATHLEEN VIRGINIA TIMMEN

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month MARCH day 13,
year 1947 hour 12: minute 25 A.M.

21. I hereby certify that I attended the deceased from MARCH
3, 1947, to MARCH 13, 1947;
that I last saw HER alive on MARCH 13, 1947,
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CLARENCE TIMMEN

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased MAY 4, 1916
(Month) (Day) (Year)

Immediate cause of death DIABETIC ACIDOSIS *Duration*

8. AGE: Years 30 Months 10 Days 09
If less than one day hr. _____ min. _____

Due to DIABETES MELLITUS

Due to _____

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

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

10. Usual occupation HOUSEWIFE

Major findings: _____
Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name SAM ROBINSON

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

14. Maiden name EMMA DIXON

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

16. (a) Informant CLARENCE TIMMEN (HUSBAND)

(b) Address 562 FOREST

17. (a) Burial (b) Date thereof 3/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Watkins

(b) Address 1729 Lydia Avenue

19. (a) 3-17-47 (b) Alexandine Holmes
(Date received local registrar) (Registrar's signature)

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? 0

While at work _____ (Specify type of place)

(e) Means of injury _____

Signature _____ (M. D. or Other) M. D.

Address GENERAL HOSPITAL NO. 2 Date signed 3/14/47

1980 NOV 1 10 58 AM SA

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.....

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.