

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED NOV 24 1947
Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4705**

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:
Kansas City General Hospital
(If not in hospital or institution, write street number or location) #1
 (d) Length of stay: In hospital or institution **36 hrs.**
(Specify whether years, months or days)
 In this community **5 years**

3. (a) PRINT FULL NAME **Eva Weathington**
 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 **Ben H. Weathington** 6. (c) Age of husband or wife if alive **55** years
 7. Birth date of deceased **December 3, 1896**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 **11** **25** hr. min.

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

10. Usual occupation **housewife**

11. Industry or business

12. Name **Allen Bullock**

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

14. Maiden name **Maggie Mayer**

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

16. (a) Informant **Ben H. Weathington**

(b) Address **2013 Monroe**

17. (a) **burial** (b) Date thereof **11-11-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunny Slope Cem. Richmond, Mo.**

18. (a) Signature of funeral director **Earp & Sons**

(b) Address **4139 E. 15th.**

19. (a) **11-10-47** (b) **Heraldine Holmes**
(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. **2013 Monroe**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **November** day **8**
 year **1947** hour **10** minute **50 P.M.**

21. I hereby certify that I attended the deceased from **November 7, 1947** to **November 8, 1947**,
 that I last saw him alive on **November 8, 1947**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Cancer of left breast with widespread metastasizes**
 Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) **50**

Major findings: Of operations

Of autopsy **See above**

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? **no**

While at work? (Specify type of place) (e) Means of injury

23. Signature **Heraldine Holmes** (M. D. or other) **MD**

Address **Gen. Hospital No. 1 24th & Cherry** Date signed

MOTHER FATHER

WRITE PLAINLY—USING 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 _____

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.