

Registration District No. **149**

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 **1 DAY**
(Specify whether years, months or days) **27 YRS.**

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. **2924 JACKSON**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME **TISHIA WASHINGTON**

3: (b) If veteran, name war **No** 3: (c) Social Security No. **None**

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

6: (b) Name of husband or wife **Bert Washington** 6: (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **DECEMBER 25, 1887**
(Month) (Day) (Year)

8. AGE: Years **60** Months **7** Days **29**
If less than one day: hr. min.

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

10. Usual occupation **AT HOME**

11. Industry or business _____

12. Name **? NORWELL**

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

14. Maiden name **SALLIE WALKER**

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

16. (a) Informant **MABEL WILSON (GRAND-DAUGHTER)**

(b) Address **2818 JACKSON**

17. (a) **Burial** (b) Date thereof **8-27-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **Blue Ridge Park**

18. (a) Signature of funeral director **Alice Bailey Funeral Home**

(b) Address **2065-7th St**

19. (a) **8-27-48** (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **AUGUST** day **24**, year **1948** hour **5**: minute **00** A. M.

21. I hereby certify that I attended the deceased from **AUGUST 23**, 1948, to **AUGUST 24**, 1948; that I last saw her alive on **AUGUST 24**, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death **GENERALIZED ARTERIO-SCLEROSIS: CEREBRAL ARTERIOSCLEROSIS WITH THROMBOSIS OF CEREBRAL ARTERIES (BILATERAL)**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **438**

Major findings: Of operations _____
Of autopsy **SAME AS 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? _____

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

23. Signature **Frank** _____ (M. D. or other)

Address **GENERAL HOSPITAL NO. 2** Date signed **8/24/48**

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

MOTHER FATHER

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 Wm. M. Overton

Licensed Embalmer No. 2007

P. O. Address. K. E. Kansas

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.