

8-30-52
AUG 30 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28324
3724

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR Kansas City	
c. LENGTH OF STAY (In this place) 33 yrs		338	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2103 Prospect		d. STREET ADDRESS (If rural, give location) 2103 Prospect	

3. NAME OF DECEASED (Type or Print) a. (First) Julia Lee b. (Middle) Tate c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 8-19-52		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 6-3-1903	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) McComb, Miss		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME John Moses	13b. MOTHER'S MAIDEN NAME Georgianna Jordan	14. NAME OF HUSBAND OR WIFE Silas Tate
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Georgianna Helen Walker
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 171A
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cachexia and Malnutrition		
	ANTECEDENT CAUSES DUE TO (b) Carcinoma of the Cervix Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) " " " "		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov. 3, 1951**, to **Aug 19, 1952**, that I last saw the deceased alive on **Aug. 19, 1952**, and that death occurred at **1:15 AM**, from the causes and on the date stated above.

23a. SIGNATURE Marion W. Richardson (Degree or title)	23b. ADDRESS 2526 Prospect	23c. DATE SIGNED 8-19-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-23-52	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town, or county) (State) Kansas City
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DATE REC'D BY LOCAL REG. 8-20-52	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Walker Bros. Funeral Home	ADDRESS 1800 Benton Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Bruce R. Watkins

Licensed Embalmer No. 4500

P. O. Address 1840 1/2 Benton Blvd.

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.