

JAN 19 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

41537

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Raw Primary Registration District No. 1002
City Kansas City (No. Wheatley Hospital St. _____ Ward _____)

File No. _____
Registered No. 2822

2. FULL NAME Luberta Tillman

(a) Residence, No. 15-10 & 10th St., _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-30 1936

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Grant Tillman

22. I HEREBY CERTIFY, That I attended deceased from Oct 11th 1936 to Nov 30th 1936

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-22-1896

I last saw her alive on Nov. 29th 1936 Death is said to have occurred on the date stated above, at 10:40 a. m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 6 8

The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis Date of onset _____

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: Arteriosclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fremont Arkansas

13. NAME Thomas Owens

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

15. MAIDEN NAME Lucy Butler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

17. INFORMANT Grant Tillman (ADDRESS) 15-10 & 10th St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ashdown DATE 12-6 1936

19. UNDERTAKER K. C. Amb. & Casket Co. (ADDRESS) 440 State Ave.

20. FILED Dec 3 1936 M. M. Crowe Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? Autopsy Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1936

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no If so, specify _____

(Signed) J. E. Cooney M. D. (Address) 440 State Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

