

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.

JAN 13 1940

399

State File No.

4632

Registration District No.

Primary Registration District No.

1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City, Mo.  
 (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 11-30 to 12-3-39  
 (Specify whether  
10 years  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1223 Vine St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Della Carliss 647

3. (b) If veteran, name war

No'

3. (c) Social Security No.

No

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Eddie

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased unknown  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 3  
 year 39 hour 6 minute 45 P. M.

21. I hereby certify that I attended the deceased from 11-30, 1939 to 12-3-, 1939  
 that I last saw her alive on 12-3, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus with Gangrene of Left Leg.

Duration

Due to 59

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

23. Signature J. C. Thomas (M. D. or other) \_\_\_\_\_  
 Address General Hospital #2 Date signed 12-5

MOTHER FATHER

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Bates Allen

13. Birthplace Mo. (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital No. 2

17. (a) (Burial, cremation, or removal) Highland Cemetery (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director Miss M. F. ...

(b) Address 1212 ...

19. (a) (Date received local registrar) Dec. 6, 1939 (b) (Registrar's signature) M. M. ...

---

---

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed.....

*Julius A. Feichter*

Licensed Embalmer No. ....

*1212 Vine St*

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, above space should be left blank.**