

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4718

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 12-1-39 to 12-9-39
(Specify whether years, months or days)
 In this community 22 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City,
(If outside city or town limits, write "RURAL")
 (d) Street No. 921 E. 17th St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 9
 year 39 hour 5 minute 50 AM.

21. I hereby certify that I attended the deceased from
12-1-, 1939, to 12-9-, 1939;
 that I last saw her alive on 12-9-39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive Type of Heart Disease with Marked Decompensation.

Due to _____

Due to _____

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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 [Signature] (M. D. or other)
 Address General Hospital #2 Date signed 12-11

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Mamie Hobbs 120

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Riley Hobbs 6. (c) Age of husband or wife if alive 56 known years

7. Birth date of deceased November 10, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>		<u>29</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Harris

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

14. Maiden name unknown

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

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

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 12-13-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1729 Lydia

19. (a) Dec. 13, 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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.

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.....

Robert M. Adams

Registered Apprentice No. *178*

working under my personal supervision.

Signed.....

T. B. Watkins

Licensed Embalmer No. *2889*

P. O. Address *1729 Lydia*

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.