

Registration District No. 399

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 1-10-40-1-16-40
(Specify whether
In this community 10 years
years, months or days)

3. (a) PRINT FULL NAME Rose Williamson

8. (b) If veteran, No name war _____ 3. (c) Social Security No. 496-16-3990

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

6. (b) Name of husband or wife T. D. Williamson 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased 3 29 1898
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>9 10</u>	<u>20</u>	hr. _____ min.

9. Birthplace Smith County Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jesse Davis

18. Birthplace Smith County Texas
(City, town, or county) (State or foreign country)

14. Maiden name Frances Benton

15. Birthplace Smith County Texas
(City, town, or county) (State or foreign country)

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

(b) Address General Hospital No. 2.

17. (a) Burial (b) Date thereof 1-25-40
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem.

18. (a) Signature of funeral director Adkins Bros.

(b) Address 2000 E. 12th

19. (a) Jan. 25, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 1615 Central (rear-base)
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18
year 40 hour 1 minute 50 A. M.

21. I hereby certify that I attended the deceased from 1-10, 1940 to 1-18, 1940
that I last saw her alive on 1-18-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Phthisis

Due to 1, 2

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) (a) Means of injury 1

28. Signature D. O. Brown (M. D. or other) _____
Address General Hospital #2 Date signed 1-19-

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Edwin J. Evans

Licensed Embalmer No. 3836

P. O. Address 1819 E 15th Mo

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.