

FILED APR 19 1940
399

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1015

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Mo. & 12 days
(Specify whether
In this community 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Tillie Walters 436

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex fe 5. Color or race wh 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John W. Walters 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Sept 6 1898
(Month) (Day) (Year)

8. AGE: Years 41 Months 5 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name Tillman F. Kendaud
13. Birthplace MO (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Ernesta Bentley
15. Birthplace MO (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John W. Walters
(b) Address 917 Forest

17. (a) Burial (b) Date thereof Mar 5 - 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home
18. (a) Signature of funeral director F. S. Wagoner
(b) Address 2738 Prospect

19. (a) 3-4-40 (b) Dr. M. L. Corow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd
year 1940 hour 1 minute 45 A.M. M.

21. I hereby certify that I attended the deceased from July - 1938, 19____, to 3-3-40, 19____; that I last saw her alive on 3-3-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of cervix with vesico vaginal fistula

Due to _____ 48

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy None

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 Dr. De Maria MD (M. D. or other) _____
Supt. K. C. General Hospital, K. C. Mo. signed

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39 N. E. 1 x 1011
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 J. S. Walton

Licensed Embalmer No. 2744

P. O. Address 3030 Harrison

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.