

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 **2-16-40-3-20-40**
(Specify whether years, months or days) **11 years**

3. (a) PRINT FULL NAME **Sallie Dillard**
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 **Widow**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **Unknown** years

7. Birth date of deceased **Unknown** **1889**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	50			hr. min.

9. Birthplace **L.A.**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business **9**

MOTHER FATHER { 12. Name **Unknown**
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** (Burial, cremation, or removal) (b) Date thereof **3/23/40**
(Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **Watkins Bros**

(b) Address **1729 Lydia**

19. (a) **Mch 22, 1940** (Date received local registrar) (b) **M. M. Brown** (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. **1816 Woodland**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **20**
year **40** hour **7** minute **45 A.** M.

21. I hereby certify that I attended the deceased from **2-16-** 19**40** to **3-20-** 19**40**
that I last saw her alive on **3-20-** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Type of Heart Disease.** Duration

Due to **Hypertension.** **9:05**

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 _____

23. Signature **J. O. Brown** (M. D. or other)

Address **Gen. Hosp. #2** Date signed **3-22**

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Isaac Jerome Manlove

Licensed Embalmer No.

3994

P. O. Address

1120 E. 23rd St

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.