

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **6528**

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 #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10-30-40-11-3-40**
(Specify whether **1** month)
In this community **1** month
years, months or days

RECORDED
DEC 11 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
City or town **Kansas City**
(If outside city or town limit, write "RURAL")
(d) Street No. **5811 E. 35th St., Terrace**
(If rural, give location)
(e) If foreign born, how long in U. S. A? **0** years.

3. (a) PRINT FULL NAME **Evelyn Wilkerson**

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

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

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

7. Birth date of deceased **10** **1** **1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 **2** _____ hr. _____ min.

9. Birthplace **Kansas City** **Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business **1**

12. Name **Cornie Wilkerson**

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

14. Maiden name **Bessie Swangain**

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

16. (a) Informant **Record Clerk**

(b) Address **Gen. Hosp. #2**

17. (a) _____ (b) Date thereof **11-5-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Blue Ridge Cemetery**

18. (a) Signature of funeral director **W. H. ...**

(b) Address **1905 Vine St.**

19. (a) **11-5-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **3**
year **40** hour **6** minute **20 P. M.**

21. I hereby certify that I attended the deceased from **10-30-** **1940** to **11-3-** **1940**
that I last saw h. **er** alive on **11-3-** **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Broncho Pneumonia (Primary)**

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 **D. O. ...** (M. D. or other)

Address **Gen. Hosp. #2** Date signed **11-3-40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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



Licensed Embalmer No. 2710

P. O. Address K. R. M. O

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.