

Registration District No. **399**

Primary Registration District No. _____

FILED DEC 11 1940

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(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 **10-7-40; 11-19-40**
In this community **17 years**
(Specify whether 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 limit, write "RURAL")
(d) Street No. **1010 Lydia**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Bessie Twyman**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **10**

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 _____ years
7. Birth date of deceased **7 16 1883**
(Month) (Day) (Year)

8. AGE: Years **57** Months **4** Days **3** If less than one day hr. _____ min. _____

9. Birthplace **Springfield, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laundress**

11. Industry or business _____

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 **Record Clerk**
(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **11-20-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **H. B. Moore**

(b) Address **1920 E-18th St**

19. (a) **11-22-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **19**
year **40** hour **6** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **10-7-40** to **11-19-40**
that I last saw her alive on **11-19-40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal Pneumonia**

Due to **Hypertensive Heart Disease**

Due to _____

Other conditions **950 756**
(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 **J. C. Thomas** (M. D. or other)

Address **Gen Hosp. #2** Date signed **11-20-40**

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 me

AB Moore Registered Apprentice No. _____
working under my personal supervision.

Signed AB Moore

Licensed Embalmer No. 2410

P. O. Address 1820 East 78th

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.