

No. 2  
1-10-39  
-17-39  
X 21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41547  
Registrar's No. 4910

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:  
K.C. General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 days  
(Specify whether  
In this community 2.5 yrs  
years, months or days)

8. (a) PRINT FULL NAME SADIE LILES

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

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

6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased 10 20 1897  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>2</u>	<u>5</u>	<u>hr. min.</u>

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

10. Usual occupation Housewife

11. Industry or business 9

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. Ford

(b) Address 1219 W. 20th St.

17. (a) Burial (b) Date thereof 12-27-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cem.

18. (a) Signature of funeral director H.H. Daniels

(b) Address 1536 Miami Ave.

19. (a) 12-27-40 (b) M. M. Crown  
(Date received local registrar) (Registrar's signature)

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")  
(d) Street No. 1219 West 20th St. Terrace  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26th  
year 1940 hour 2 minute 10 A.M. M.

21. I hereby certify that I attended the deceased from 12-16-40 19 to 12-26-40 19;  
that I last saw her alive on 12-26-40 19;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary thrombosis, right; Hemorrhagic cystitis

Due to Tuberc Dorsalis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy See above

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

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)  
Means of injury \_\_\_\_\_

23. Signature Mary R. Shore (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

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

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**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.....

P. O. Address.....

**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.**