

No. 2
1-13-40
-17-39
I X23159

1941 MAR 14 1941 399
Registration District No. _____

Primary Registration District No. 1002

46
83
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: 223 E 31st
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 1 year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson ⁴⁸

(c) City or town Kansas City ³
(If outside city or town limits, write "RURAL") ⁸

(d) Street No. 223 E 31st
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Julia Mabel Hillenbrand

3. (b) If veteran, name war _____

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 1
year 41 hour 8 minute 30 a. M.

21. I hereby certify that I attended the deceased from Aug 21, 1940 to Feb 1, 1941
that I last saw her alive on Feb 1 - 41, 19____; and that death occurred on the date and hour stated above.

4. Sex Female 5. Color White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Charles Hillenbrand

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

7. Birth date of deceased: 5 - 5 - 1876
(Month) (Day) (Year)

Immediate cause of death Respiratory Comp

Due to Quack Injections

Due to !

Other conditions (Include pregnancy within 3 months of death) none

8. AGE: Years 64 Months 8 Days 26 If less than one day _____ hr. _____ min.

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

Major findings: Of operations no

Of autopsy no

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name J. B. Hillenbrand

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

14. Maiden name Sarah E. Beestick

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

16. (a) Informant Mrs. W. M. Lindley

(b) Address Wichita, Kansas

17. (a) Burial (b) Date thereof 2-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wichita

18. (a) Signature of funeral director W. C. L.

(b) Address _____

19. (a) 2-3-41 (b) M. M. Craue
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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 D

23. Signature Ernest W. Cavaness, M.D.
Ernest W. Cavaness, M.D. (M.D. or other)
925 ARGYLE BUILDING Date signed 2-1-41

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. *2798*

P. O. Address *Kansas City, Mo*

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, fact should be so stated above.