

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. Tuberculosis Hosp. - D  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-yr. 6-mo.  
(Specify whether years, months or days)  
In this community 18-years

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. 623 E. 6th  
(If rural, give location)  
(e) Citizen of foreign country? 1 (Yes or No)  
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31  
year 1941 hour 8:00 AM minute 15 M.  
21. I hereby certify that I attended the deceased from 10-2-39  
1939 to 3-31 1941

that I last saw her alive on 3-31- 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Fat. advanced pulmonary tuberculosis  
Duration

Due to 12/12  
Due to 12/12

Other conditions 12/12  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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)  
(e) Means of injury \_\_\_\_\_

23. Signature Dr. Peyer MD (M. D. or other) \_\_\_\_\_  
Address K.C. The Hospital Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Morrison Willa Mae

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

4. Sex Female 5. Color or race Colored 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 Sept. 23 1899  
(Month) (Day) (Year)

8. AGE: Years 41 Months 6 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jesus (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Don't know

13. Birthplace Don't know (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

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

16. (a) Informant Lillian Phillips

(b) Address 623 E. 6th

17. (a) Burial (b) Date thereof 4-8-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director W. H. Appleton Jones

(b) Address K.C. Mo.

19. (a) Apr 1941 (b) M. D. Brown  
(Date received local registrar) (Registrar's signature)

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.....

*C. H. West*

Licensed Embalmer No.....

*2710*

P. O. Address.....

*Kansas City*

**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.**