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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

194 STANDARD CERTIFICATE OF DEATH

20713

State File No.

FILED JUL 7 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2243

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: Research Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: (Specify whether years, months or days) 3 hrs.

In this community:

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.: 4236 Brooklyn (If rural, give location)

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

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3. (a) PRINT FULL NAME: Babe Tillett Al

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: Boy

5. Color or race: W.

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: May (Month) 31 (Day) 1941 (Year)

8. AGE: Years — Months — Days — If less than one day: 2 hr. 20 min.

9. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Bryce Donald Tillett
13. Birthplace: Turney (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Nancy Rosena Thomas
15. Birthplace: Moreadia (City, town, or county) Kansas (State or foreign country)

16. (a) Informant: Research Hospital
(b) Address: 23rd & Holmes

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: June 4 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Research Hospital

18. (a) Signature of funeral director: None
(b) Address:

19. (a) 6/11/1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1941 hour 710 minute 55 A. M.

21. I hereby certify that I attended the deceased from May 31 10 55 AM, 19 41, to 1:35 PM May 31, 19 41; that I last saw him alive on May 31, 19 41; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Retroplacental Hemorrhage	
Due to: 1.0C	
Due to: 1.0C	
Other conditions (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? (Specify type of place)
While at work?
(e) Means of injury: 0

23. Signature: Don Carlos Guffey M.D. (M. D. or other)
Address: 712 Professional Bldg. Date signed: 6/20/41

(Licensed Embalmer's Statement on Reverse Side)

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.