

FILED MAR 5 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 002

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:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)

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

In this community 40 Years

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. 2626 Prospect
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME Lillian C. Free

3. (b) If veteran, name war. No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married. 2 divorced. Widow

6. (b) Name of husband or wife Lyman L. Free

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

7. Birth date of deceased 7 -27- 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

66 6 22 hr. min.

9. Birthplace. Sweet Springs Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Music Teacher

11. Industry or business Personal Lessons

12. Name James Z. Wells

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

14. Maiden name Mary C. Van Dyke

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

16. (a) Informant Mr. B. V. Wells

(b) Address 2424 Kensington

17. (a) Burial (b) Date thereof 2-22-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Missouri

19. (a) 2/22/43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19th.
year 1943 hour 11 minute 30 A. M.

21. I hereby certify that I attended the deceased from Pathologist 19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized peritonitis

Due to purulent pelvic infection with necrosis of uterus and bladder walls.

Due to 139a

Other conditions 139a
(include pregnancy within 3 months of death)

Major findings: Generalized peritonitis

Of operations Generalized peritonitis

Of autopsy Same

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

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence None

(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.....

23. Signature R. L. St. Clair C. (M. D. or other)
Dr. Marie Sherwood, M. D. Date signed 2-19-43
Pathologist, St. Joseph Hosp, K.C., Mo.

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..... *Theron A. Redman*

Licensed Embalmer No. *2737*

P. O. Address..... *N.P. 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.