

Registration District No. 149

Primary Registration District No. 1002

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: General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 25 Days  
(Specify whether  
In this community 20 yrs  
years, months or days)

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. South Side Hotel 31 + Harrison  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Bertha Isabell Mitchell

3. (b) If veteran, name war no 3. (c) Social Security No. 494-12-603

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 1 Married

6. (b) Name of husband or wife Leonard A Mitchell 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased Nov-8 1907  
(Month) (Day) (Year)

8. AGE: Years 35 Months 4 Days 21 If less than one day hr. min.

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

10. Usual occupation Checker

MOTHER FATHER

11. Industry or business La Salle Cleaners

12. Name Wm Harvey Garrison

13. Birthplace no A  
(City, town, or county) (State or foreign country)

14. Maiden name Geneviva Tremaine

15. Birthplace no A  
(City, town, or county) (State or foreign country)

16. (a) Informant Leonard A Mitchell

(b) Address 1912-E-42 St

17. (a) Burial (b) Date thereof April 1-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs. C. R. Foster

(b) Address 915 Brooklyn

19. (a) 3-31-43 (b) M. M. Groves  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29  
5 - year 1943 hour 2 minute 8 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease

Due to Curse of Lee

Due to 124 B'

Other conditions (include pregnancy within 3 months of death)

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

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)  
23. Signature Dr. H. J. ... (M. D. or other)  
Address 2316 Mc Coy Date signed 3/31/43

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

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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, fact should be so stated above.**