

Registration District No. 1002

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: KANSAS CITY Tuberculosis Hosp. 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 4 months  
(Specify whether years, months or days) 4 yrs

In this community. 4 yrs

3. (a) PRINT FULL NAME Dorothy McBride

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

3. (c) Social Security No. None

4. Sex. FEMALE 5. Color or race. 3 Negro

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. July 6 1921  
(Month) (Day) (Year)

8. AGE: Years 21 Months 9 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation. maid

11. Industry or business.

MOTHER FATHER

12. Name. Thomas Byrd McBride

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

14. Maiden name. EVA TAYLOR

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

16. (a) Informant. Patient - from Hospital record

(b) Address. K.C. TB Hosp.

17. (a) Burial (b) Date thereof. 4-21-43  
(Method, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. guest house K.C.H.

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

(b) Address. 440 State Ave. Brown

19. (a) 4-21-43 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: Wyanolotte

(a) State. Mo. (b) County. Jackson

(c) City or town. KANSAS CITY 14  
(If outside city or town limits, write "RURAL.") 0

(d) Street No. 2601 N. Allis  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country. 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month. APRIL day. 16  
year. 1943 hour. 5:30 minute. PM M.

21. I hereby certify that I attended the deceased from 2-8-43  
\_\_\_\_\_, 19\_\_\_\_, to 4-16-43, 19\_\_\_\_,  
that I last saw her alive on 4-16-43, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death. Pulmonary Tuberculosis 1 yr 2 mos  
Duration

Due to. 13 D

Due to.

Other conditions. Tuberculosis Enteritis 3 mos  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations. \_\_\_\_\_

Of autopsy. as above

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? \_\_\_\_\_

23. Signature. Matthew J. Noon (M. D. or other) \_\_\_\_\_  
Address. K.C. TB Hosp. Date signed. 4/14/43

**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 *Eugene English*.....

Licensed Embalmer No. *4105*.....

P. O. Address. *440 State Ave. K.C.*.....

**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.**