

FILED MAY 3 1943
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 No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-1-43 6 hr.
(Specify whether lifetime)

In this community _____
(years, months or days)

3. (a) PRINT FULL NAME ELIZABETH MONROE

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female 5. Color negro 6. (a) Single, widowed, married, divorced married
race Bosni

6. (b) Name of husband or wife William Monroe 6. (c) Age of husband or wife if alive unk years
1887

7. Birth date of deceased March 31
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>0</u>	<u>0</u>	_____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Miller Burris

13. Birthplace Fayette Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Anna Lyles

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

16. (a) Informant Record Clerk
(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 4-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Kerns

18. (a) Signature of funeral director J. Flynn + Greenstreet
(b) Address 1819 E. 15th Kerns

19. (a) 4/6/43 (b) M. M. Gram
(Date received local registrar) (Registrar's signature)

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. 1307 E. 13
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1943 hour 11:05 minute 0 M.

21. I hereby certify that I attended the deceased from 4-1-43
4:45 p.m. to 11:05 p.m., 1943
that I last saw her alive on April 1, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive heart failure

Due to Rheumatic type heart disease

Due to _____ 95B

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy _____

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)

Means of injury _____

23. Signature [Signature] M. D. _____
Address Gen. Hosp #2-606 E. 23 Date signed 4-3-43

Born 5-27-1901

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 W. G. Johnson
Licensed Embalmer No. 2211
P. O. Address 1819 E. 15th KC2

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.