

Registration District No. **149**

Primary Registration District No. **1002**

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:
Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution **6 Days**
(Specify whether
In this community **Lifetime**
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. **24 East 53rd Street**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mr. Daniel C Bilbee**

3. (b) If veteran, **World War 1** name war. 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or Race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Nell Bilbee** 6. (c) Age of husband or wife if alive **45** years

7. Birth date of deceased **December 16 1896**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 8 0 hr. min.

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

10. Usual occupation **Retired**

11. Industry or business **Clerk**

MOTHER FATHER { 12. Name **John P. Bilbee**
13. Birthplace **Dayton Ohio**
(City, town, or county) (State or foreign country)
14. Maiden name **Rose Mary Porter**
15. Birthplace **Watseka Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank R. Bilbee**

(b) Address **3301 Paseo**

17. (a) **Burial** (b) Date thereof **Aug. 18 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Washington Cemetery**

18. (a) Signature of funeral director **W. H. Newcomer**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **8-18-43** (b) **W. C. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **16**
year **1943** hour **10** minute **13 P.M.**

21. I hereby certify that I attended the deceased from **Aug 8-43**
to **Aug 16 1943**
that I last saw him alive on **Aug 16 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia** Duration **3 days**

Due to _____
Due to **109**

Other conditions **Epilepsy** **7 yrs**
(Include pregnancy within 6 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **J. W. Grainger M.D.** (M. D. or other) **0**
Address **3104 Broadway R.C. M.D.** Date signed **7-17-43**

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

