

No. 2
8-43
7-39
X37823

FILED JUL 15 1944

Registration District No. 177 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:
2626 Brooklyn
(If not in hospital or institution, write street number & location)
(d) Length of stay: 8 mo (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Luricia William

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Elijah Williams
6. (c) Age of husband or wife if alive 80 years
7. Birth (date of deceased) 5 20 1867
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 12 hr. min.

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

10. Usual occupation house wife

11. Industry or business own home

12. Name Sam Davis

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

14. Maiden name Phillis (unknown)

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

16. (a) Informant Elijah Williams

(b) Address 1810 N. 1st. K. C. Kans.

17. (a) Burial (b) Date thereof 7-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Highland

18. (e) Signature of funeral director Mrs. J. W. Jones

(b) Address 440 State ave

19. (a) 7-3-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas city 1838
(If outside city or town limits, write "RURAL")
(d) Street No. 1811 N. 1st. St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 2
year 1944 hour 7:19 a.m. minute 00 M.

21. I hereby certify that I attended the deceased from June 27
1944, to July 2, 1944
that I last saw her alive on July 1st, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death congestive heart failure Duration
hypertensive heart disease

Due to hypertensive heart disease

Due to 93d

Other conditions 93d
(include pregnancy within 3 months of death)

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:

(c) 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 Samuel Weeks (M. D. or other)

Address 2204 E 18th St. K. C. Mo Date signed 7-3-44

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.....

Eugene English

Licensed Embalmer No. *4825*

P. O. Address. *440 State Ave. 1*

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.