

FILED JUN 29 1944  
Registration District No. **1944**

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**  
(c) Name of hospital or institution: **K.C. General Hospital No. 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 days**  
In this community **67 yrs**  
years, months or days

3. (a) PRINT FULL NAME **Carrie Willix**  
3. (b) If veteran, name war **no**  
3. (c) Social Security No. **none**

4. Sex **Female**  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced **widow**  
(b) Name of husband or wife **Fred Edward Willix**  
6. (c) Age of husband or wife if alive **years**  
7. Birth date of deceased **July - 24 - 1876**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **10** Days **24**  
If less than one day **hr. min.**

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

10. Usual occupation **Retired**

11. Industry or business  
12. Name **John Murphy**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary - Bohan**  
15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mo Jessie - Sartin**  
(b) Address **59th Blue Ridge Cut Off**

17. (a) **Burial**  
(Burial, cremation, or removal)  
(b) Date thereof **June - 19 - 44**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**  
18. (a) Signature of funeral director **A. P. Doster**  
(b) Address **1415 East 15**

19. (a) **6-17-44**  
(Date received local registrar)  
(b) **N. E. Brown**  
(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. **1429 Brooklyn**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **15th**  
year **1944** hour **11:00 P.M.** minute **M.**

21. I hereby certify that I attended the deceased from **6-8-1944** to **6-15-44**  
that I last saw her alive on **6-15-44**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetic mellitus with acidosis.**  
Due to

Due to

Other conditions **wt**  
(include pregnancy within 3 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?

(Specify type of place)  
While at work (e) Means of injury  
24. Signature **A. E. Upsher** (M. D. or other)  
Address **Med. Dir K.C. Gen. Hospital** **6-16-44**

**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 *H. P. Doehler*

Licensed Embalmer No. 1166

P. O. Address 1415 East 15

**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.**