

7. S. No. 2
FORM-2-43
Rev. 5-17-39
1 X39697

FILED NOV 14 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
(If outside city or town limits, write "RURAL" and name of township)

(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 19 days
(Specify whether)

In this community 21 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **49**

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 18 E. 9 St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Lillie Combs

(b) If veteran, name war No.

(c) Social Security No. 486-07-4672

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2
year 1944 hour 2 minute 10 P.M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife James Lewis Combs

(c) Age of husband or wife if alive 64 years

7. Birth date of deceased: April 9 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct. 15, 1944 to Nov. 2, 1944
that I last saw her alive on Nov. 2, 1944
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>51</u>	<u>6</u>	<u>23</u>	hr. _____ min. _____

Immediate cause of death Hypertensive cardio vascular disease Duration

9. Birthplace Camden Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Due to _____

Due to _____ **93 d**

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

MOTHER FATHER {

11. Industry or business _____

12. Name Hiram Johnston

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

14. Maiden name Fannie Wollery

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

Major findings: _____

Of operations _____

Of autopsy See above

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant James M. Combs

(b) Address 810 E. 10th. St.

17. (a) Burial _____ (b) Date thereof 11 7 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Birch Tree Missouri

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918-920 Brooklyn

19. (a) 11-3-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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 A. E. Upsher (M. D. or _____) **MS**
Address Med. Dir. Gen'l Hosp. Date signed 11-3-44

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

J. W. Henrich
Licensed Embalmer No. *3599*
P. O. Address *Dr. C. Mo*

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.