

FILED FEB 14 1945  
Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 492

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2204 1/2 East 15th Street.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
(Specify whether  
In this community 62 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42  
(c) City or town Kansas City Mo. 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2204 1/2 East 15th, Street. 8  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country U

3. (a) PRINT FULL NAME Harry M. LILLIS.

3. (b) If veteran, name war NONE. 3. (c) Social Security No. 492-18-0669.

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

6. (b) Name of husband or wife Mrs. Artie Lillis 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased January 4th, 1883  
(Month) (Day) (Year)

8. AGE: Years 62 Months 00 Days 23 If less than one day hr. min.

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

10. Usual occupation Brick Layer.

11. Industry or business

MOTHER FATHER

12. Name Michael Lillis

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

14. Maiden name Mary Kennedy

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

16. (a) Informant Mrs. Artie Lillis

(b) Address 2204 1/2 East 15th, Street

17. (a) Burial (b) Date thereof 1/30/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Melody McGilley.

(b) Address K. C. Mo.

19. (a) 1-31-45 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 27th  
year 1945 hour 8 minute 55 P. M.

21. I hereby certify that I attended the deceased from Jan 4-45  
to Jan 27, 1945.  
that I last saw him alive on Jan - 26, 1945.  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Myocarditis Ch  
Interstitial Nephritis Ch  
Due to  
Due to

Other conditions (Include pregnancy within 3 months of death) 131a

Major findings: Of operations

Of autopsy

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) (c) Means of injury

23. Signature R. B. Fair (M. D.)  
Address 2200 E. 15th Date signed 1/29/45

~~\_\_\_\_\_~~ 4-P.M  
~~\_\_\_\_\_~~  
V: \_\_\_\_\_

1132  
Parrot  
Parrot  
2200 E. 15

**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.....  
Licensed Embalmer No.....  
P. O. Address.....

**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.**