

FILED MAR 2 1946

Registration District No.

Primary Registration District No. 1002

Registrar's No.

808

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:
1312 Brooklyn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 2 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bobbie Lee West

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 divorced
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive years
7. Birth date of deceased: (Month) 8 (Day) 12 (Year) 1891

8. AGE: Years 54 Months 6 Days 1 If less than one day hr. min.

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

10. Usual occupation House Work

11. Industry or business at Home

12. Name Roscoe West

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

14. Maiden name Susie Carter

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

16. (a) Informant Minnie V. Johnson

(b) Address 623 New Jersey

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-46 (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope, K.C.M.

18. (a) Signature of funeral director W. Jones

(b) Address 440 State Ave. K.C.M.

19. (a) 2-16-46 (Date received local registrar) (b) Maldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ohio (b) County Hamilton
(c) City or town Cincinnati
(If outside city or town limits, write "RURAL")
(d) Street No. 535 West 5th St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 13 year 1946 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from 2-7 1946 to 2-13 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the uterus Duration unknown

Due to Secondary Anemia unknown

Due to Carcinoma

Other conditions (Include pregnancy within 3 months of death) none

Major findings: Of operations 485

Of autopsy none

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? no (Specify type of injury) (e) Means of injury

23. Signature Wm. A. Love (M.D. or other)

Address 1820 N. 3rd St. K.C.M. Date signed 2-16-46

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

38

999
33
0

Duration
unknown

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

Dr. Love

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. *4405*
P. O. Address *440 State Ave*

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.