

S. No. 2
DOM-2-43
v. 5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 10 1946
Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 979762
Registrar's No. 1588

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:
General Hospital No. 20
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos. 23 days
(Specify whether
In this community 6 mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1100 Park 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

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

4. Sex Female 3
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased September 22 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 6 Days 8
If less than one day
hr. _____ min. _____

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

10. Usual occupation None
11. Industry or business None

12. Name of Sam Hawkins
13. Birthplace Texas
(City, town, or county) (State or foreign country)
14. Maiden name Ora
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Medical Records Librarian
(b) Address General Hospital No. 2

17. (a) burial (b) Date thereof 4/2/46
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address 1212 Eldridge St

19. (a) 4-2-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 30,
year 1946 hour 1: minute 45 A. M.
21. I hereby certify that I attended the deceased from November 7,
1946 to March 30, 1946,
that I last saw her alive on March 30, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho Pneumonia
Duration _____

Due to General Arteriosclerosis
Due to Arteriolar Nephrosclerosis

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

Major findings:
Of operations _____
Of autopsy (Same as above)
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?

23. Signature E. D. [unclear] (M. D. or other) _____
Address General Hospital No. 2 Date signed 3/30/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
8688

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

E. Sterling Bull

Licensed Embalmer No. *3178*

P. O. Address *1212 Pine*
St. 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.