

S. No. 2
M-5-43
5-17-39
p I X3667

FILED JUL 12 1946

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: **RESEARCH HOSPITAL 0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 DAYS** (Specify whether)

In this community **46 YEARS** (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. **3903 FLORA AVENUE 8**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No) **0**

If yes, name country _____

3. (a) PRINT FULL NAME **CELIA EASLEY**

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 **MARRIED**

6. (b) Name of husband or wife **MR. JOHN R. EASLEY**

6. (c) Age of husband or wife if alive **56** years

7. Birth date of deceased **JAN 22 1900**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **JUNE** day **15** year **1946** hour **8** minute **20 P.M.**

21. I hereby certify that I attended the deceased from **May 1**, 1946, to **June 15**, 1946, that I last saw **her** alive on **6-15-46** and that death occurred on the date and hour stated above.

8. AGE: Years **46** Months **4** Days **24 23** hr. min.

Immediate cause of death **meningitis tuberculosis** **8 weeks**

Due to **Tbc of chest & Kidney 2 yrs**

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

Major findings: **138**

Of operations _____

Of autopsy **none**

10. Usual occupation **HOUSEWIFE**

11. Industry or business **AT HOME**

MOTHER FATHER

12. Name **Robert S. Wilson**

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

14. Maiden name **Jda Melvin**

15. Birthplace **Xenia Ohio**
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr. John R. Easley**

(b) Address **3903 Flora**

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? _____

17. (a) **BURIAL** (b) Date thereof **June 17, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FOREST HILL CEMETERY**

18. (a) Signature of funeral director **D W Newberry & Sons**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **6-17-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) _____ (Means of injury)

22. Signature **J. G. Patten** (M. D. or other) **0**

Address **724 Prop Bldg KC Mo** Date signed **6-16-46**

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

6904 Valley

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 Paul Repp
Licensed Embalmer No. 3458
P. O. Address K.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.