

No. 2
-12-45
-5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37001**
Registrar's No. **4987**

FILED DEC 9 1946
Registration District No. **1799**

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. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 DAYS**
(Specify whether years, months or days) **17 YRS.**

3. (a) PRINT FULL NAME **HILLIARD HENRY**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **527-01-9945**

4. Sex **MALE** 2 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **Faye Henry** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **OCTOBER 12, 1901**
(Month) (Day) (Year)

8. AGE: Years **45** Months **1** Days **12** If less than one day hr. min.

9. Birthplace **ATKINS ARKANSAS**
(City, town, or county) (State or foreign country)

10. Usual occupation **COMMON LABORER**

11. Industry or business _____

12. Name **WILLIAM HENRY**

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

14. Maiden name **MARY THOMPSON**

15. Birthplace **Atkins ARKANSAS**
(City, town, or county) (State or foreign country)

16. (c) Informant **OPHELIA COX (SISTER)**

(b) Address **1617 TRACY**

17. (a) **Burial** (b) Date thereof **11/29/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (a) Signature of funeral director **Watkins Bros.**

(b) Address **1729 Lydia Avenue**

19. (a) **11-27-46** (b) **Heraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **1224 PASEO**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **24**,
year **1946** hour **10**: minute **10** A. M.

21. I hereby certify that I attended the deceased from **NOVEMBER 22, 1946** to **NOVEMBER 24, 1946**
that I last saw him alive on **NOVEMBER 24, 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL VASCULAR ACCIDENT** Duration _____

Due to **HYPERTENSIVE HEART DISEASE**

Due to _____

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

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 _____ (M. D. or other) **M. D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **11/25/46**

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

33061

44
3
8
0

938

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

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. Jerome Maxlowe

Licensed Embalmer No. *3994*

P. O. Address.. *2503 Highland*

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.