

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 10 1947
1947

UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5119**
Registrar's No. **905**

Registration District No. **1947** 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 **7 DAYS**
(Specify whether
In this community **33 Years**
years, months or days)

3. (a) PRINT FULL NAME **LIZZIE WASHINGTON**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No No**

4. Sex **FEMALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **Prime Washington** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **Unknown** **1871**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 hr. min.

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

10. Usual occupation **At Home**

11. Industry or business

12. Name **LAMB**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **ANNIE COPELAND**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **MAGGIE CLARK (DAUGHTER)**
(b) Address **1505 HARRISON**

17. (a) **Burial** (b) Date thereof **2/28/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Watkins, Brad**
(b) Address **1739 S. Lydia Ave**

19. (a) **2-27-47** (b) **Geraldine Helms**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **48**
(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **1617 TRACY**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEBRUARY** day **25**,
year **1947** hour **8:** minute **20 P. M.**
21. I hereby certify that I attended the deceased from **FEBRUARY**
18, 19 **47** to **FEBRUARY 25**, 19 **47**;
that I last saw **HER** alive on **FEBRUARY 25**, 19 **47**;
and that death occurred on the date and hour stated above.

Immediate cause of death **ACUTE CIRCULATORY AND RESPIRATORY FAILURE**
Due to **ARTERIOSCLEROTIC HEART DISEASE**

Due to **GENERALIZED ARTERIOSCLEROSIS**

Other conditions (Include pregnancy within 5 months of death)

Major findings: Of operations
Of autopsy **93**
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?

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

23. Signature **G. J. Sink** (M. D. or other) **M. D.**
Address **GENERAL HOSPITAL NO. 2** Date signed **2/26/47**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

*certified
copy*

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 Maxlove

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.