

FILED APR 8 1947

Registration District No. 149

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
In this community 54 YRS.
(Specify whether years, months or days)

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. 1612 E. 10TH ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME MOLLIE STEED

3. (b) If veteran, name war NO 3. (c) Social Security No. none

4. Sex FEMALE 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 MAY 7, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	10	13	hr. min.

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

10. Usual occupation at home

11. Industry or business

12. Name PARIS JAMES

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

14. Maiden name BETTY

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

16. (a) Informant GENEVA BANKS (NIECE)

(b) Address 1108 E. 24TH ST.

17. (a) Burial (b) Date thereof 3-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lied Church

18. (a) Signature of funeral director Wm A. Schreyer

(b) Address City

19. (a) 3-29-47 (b) Theraldine Holmes
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 20, year 1947 hour 2: minute 10 A. M.

21. I hereby certify that I attended the deceased from MARCH 19, 1947 to MARCH 20, 1947.

that I last saw him alive on MARCH 20, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY TUBERCULOSIS
TERMINAL BRONCHO-PNEUMONIA

Due to

Due to

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?

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

23. Signature Frank Jones (M. D. or other) M. D.

Address GENERAL HOSPITAL NO. 2 Date signed 3/20/47

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

MOTHER FATHER

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.....

not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3089*.....

P. O. Address *11 E MD*.....

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.