

No. 2
15-43
17-39
936671

FILED JUL 24 1947

Registration District No. **7**

Primary Registration District No. **5-568**

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

1. PLACE OF DEATH:
 (a) County **Jackson**
 (b) City or town **Kansas City (Blue Springs)**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Residence 557 Crescent**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 year**
36 years (Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME **MRS. MINNIE LEE WILLHOIT**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **female** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **March 22, 1885**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	3	9	hr. min.

9. Birthplace **Gleanfield, Tenn.**
 (City, town, or county) (State or foreign country)
10. Usual occupation **housewife**

11. Industry or business _____
12. Name **John Thatch**
13. Birthplace **unknown**
 (City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Alvin Willhoit**
(b) Address **557 Crescent Kansas City, Mo.**
17. (a) burial **(b) Date thereof** **7/5/47**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Mt. Washington**
18. (a) Signature of funeral director **Geo. C. Carson Funeral Independence, Mo.**
(b) Address _____
19. (a) 7-15-47 **(b) [Signature]**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson 48**
 (c) City or town **Kansas City, Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **557 Crescent**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **July** day **1**
 year **1947** hour **11:45** minute **P** M.
21. I hereby certify that I attended the deceased from **July 1, 1947** to **July 1, 1947**
 that I last saw her alive on **July 1, 1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
acute pulmonary edema	20 min
Due to acute left heart failure	20 min
Due to arteriosclerosis	 yrs
Other conditions _____	
(Include pregnancy within 3 months of death)	

PHYSICIAN
 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)
 (e) Means of injury _____
23. Signature **Vance E. Kirk** (M.D. or other)
 Address **129 W. Lexington, Independence, Mo.** Date signed **7/2/47**

JUL 25 1949

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.....

William H. Schlanke, Registered Apprentice No. *439*
working under my personal supervision.

Signed.....

R. A. Lisle

Licensed Embalmer No. *4123*

P. O. Address.....

Independence, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *1000*

Registrar's No. *210*

Registration District No. _____

Primary Registration District No. *5568*

1. PLACE OF DEATH:

(a) County *Jackson*
(b) City or town *Kansas City, Rural, Blue*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence 557 Crescent
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Jackson*
(c) City or town *Kansas City, Rural*
(If outside city or town limits, write "RURAL")
(d) Street No. *557 Crescent*
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME *Minnie S. Wellhart*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 5. Color or race *W.* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *March 2, 1884*
(Month) (Day) (Year)

8. AGE: Years *62* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year *1947* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

24520