

MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No.

40173

FILED DEC 29 1948

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

5064

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 # 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 23 hrs, & 45 mins
 (Specify whether
 In this community 1 day, 3 hrs, & 45 minutes
 years, months or days)

3. (a) PRINT
 FULL NAME

J. HILL

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 SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive years

7. Birth date of deceased NOVEMBER 13th 1948
 (Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

1

3 hr.

45 min.

9. Birthplace KANSAS CITY, MISSOURI

(City, town, or county)

(State or foreign country)

10. Usual occupation

infant

11. Industry or business

12. Name

HILL

13. Birthplace

(City, town, or county)

unknown

(State or foreign country)

14. Maiden name

BERTHA MAE PRYOR

15. Birthplace

(City, town, or county)

KANSAS CITY, MISSOURI

Moth: Bertha Mae Hill

16. (a) Informant

(b) Address 1615 Montgall

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

12-14-48

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12-13-48

(Date received local registrar)

(b) Thereldine Holmes

(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. 1615 MONTGALL
 (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 14th
 year 1948 hour 11:30 minute A.M. M.

21. I hereby certify that I attended the deceased from
NOVEMBER 13, 1948 to NOVEMBER 14th 1948
 that I last saw her alive on NOVEMBER 14th 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death

RESPIRATORY FAILURE

Due to PREMATURITY

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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?

E. Frank Ellis

(Specify type of place)

While at work

(e) Means of injury

23. Signature E. Frank Ellis (M.D. or other)

Address 600 East 22nd St.

Date signed 11/15/48

(Licensed Embalmer's Statement on Reverse Side)

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 Wm A. Schuyler

Licensed Embalmer No. 3089

P. O. Address ITC 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.