

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **1076**
Registrar's No. **36**Registration District No. **399**Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City, Missouri**
 (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 **3 days**
 (Specify whether
 In this community **15 days**
 years, months or days)

3. (a) PRINT FULL NAME **Thelbert Washington**

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

4. Sex **Male** 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 **12-15-40**
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days **18** If less than one day _____ hr. _____ min.9. Birthplace **Kansas City**
(City, town, or county) (State or foreign country)10. Usual occupation **Infant**

11. Industry or business _____

12. Name **None**
13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name **Lurlene Washington**
15. Birthplace **Nebraska**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Record Clerk**
(b) Address **General Hospital #2**17. (a) **Burial** (b) Date thereof **1 4 41**
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation **Lindenworn**18. (a) Signature of funeral director **W. P. Renny**
(b) Address **1905 E 14**19. (a) **Jan 4, 1941** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **MC**
 (c) City or town **Kansas City** **3**
 (If outside city or town limits, write "RURAL") **8**
 (d) Street No. **1601 E. 14th St.** **0**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **2**
year **1941** hour **2** minute **55 P.** M.21. I hereby certify that I attended the deceased from **12-31-40**
_____, 19____, to **1-2-41**, 19____;
that I last saw him alive on **1-2-41**, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death _____
Atelectasis (congenital)

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 **W. P. Renny** (M. D. or other) _____
General Hospital #2 Date signed **1-2-41**

Duration

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.