

FILED MAR 14 1941

Registration District No. **399**

Primary Registration District No. **1002**

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

18  
3  
8

1. PLACE OF DEATH: *Jackson*

(a) County *Jackson*

(b) City or town *Kansas City Mo.*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *K. C. M. T. B. Hospital* **O**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *2 mos. 26 days*  
(Specify whether)

In this community *1 year*  
years, months or days

2. USUAL RESIDENCE OF DECEASED: **48**

(a) State *Mo.* (b) County *Jackson* **58**

(c) City or town *Kansas City*  
(If outside city or town limits, write "RURAL")

(d) Street No. *1511 - 810 st.* **O**  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME *Ellison Timothy*

3. (b) If veteran, name war *no*

3. (c) Social Security No. *510-05-3093*

4. Sex *male* Color or race *negro*

6. (a) Single, widowed, married, divorced *married*

6. (b) Name of husband or wife *Mary Ellison*

6. (c) Age of husband or wife if alive *34* years

7. Birth date of deceased *July 10 1904*  
(Month) (Day) (Year)

8. AGE: Years *36* Months *6* Days *20* If less than one day  
hr. min.

9. Birthplace *Union Parish La.*  
(City, town, or county) (State or foreign country)

10. Usual occupation *Laborer*

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name *Ellison Manuel*

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

14. Maiden name *Fisks Pearl*

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

16. (a) Informant *K. C. M. T. B. Hospital*

(b) Address *Beeds Mo.*

17. (a) *Burial* (b) Date thereof *2-6-41*  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation *West Lawn*

18. (a) Signature of funeral director *Mrs. C. W. Jones*

(b) Address *4440 State Ave. K. C. Mo.*

19. (a) *4/19/41* (b) *M. M. Brown*  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *January* day *30<sup>th</sup>*  
year *1941* hour *7:40* minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from *Nov. 4,* 19*40*, to *Jan. 30,* 19*41*;  
that I last saw *him* alive on *Jan. 30,* 19*41*;  
and that death occurred on the date and hour stated above.

Immediate cause of death *far advanced pulmonary tuberculosis*

Due to \_\_\_\_\_

Due to *1310*

Other conditions (include pregnancy within 3 months of death) *1310*

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 *Ch. Hagen* (M. D. or other) *Phys.*

Address *K.C. T.B. Hospital K.C. Mo.* Date signed *4/19/41*

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

*Regene English*  
working under my personal supervision.

Registered Apprentice No.

Signed

*Regene English*

Licensed Embalmer, No.

*4685*

P. O. Address

*442 State Ave. 1*

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.