

FILED
JAN 21 1943 149

Registration District No. 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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
(Specify whether
In this community unknown
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. 1832 Benton
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME THOMAS FERRIL

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid.
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive years
7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years 80 Months Days If less than one day
hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER
12. Name John Ferril
13. Birthplace Temp 1
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Woodhouse
15. Birthplace D. Franklin
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Clark

(b) Address H.C. Sun Dept

17. (a) Burial (b) Date thereof 1-7-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Secretary

18. (a) Signature of funeral director Skus A. Palmer

(b) Address City Mortician

19. (a) 1-8-43 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5th
year 1943 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 12-21 1942 to 1-5-43 1943;
that I last saw him alive on 1-5-43 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Intertrochanteric fracture of femur, rt. accidental fall
Due to
Due to 186a
18
Other conditions Hypostatic bronchopneumonia
(Include pregnancy within 9 months of death)

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy See above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident 123
(b) Date of occurrence 12-21-42
(c) Where did injury occur? K.C. Jackson Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work? (Specify type of place) (e) Means of injury Fall
23. Signature Amey R. Thov (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

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

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, fact should be so stated above.