

ED MAR 15 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1095

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 419 West 75
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community many yrs.
years, months or days)

3. (a) PRINT FULL NAME THOMAS-J-ATTERBERRY

3. (b) If veteran, name war no. 8. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife Lula Atteberry 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Feb 14 1899
(Month) (Day) (Year)

8. AGE: Years 44 Months 0 Days 18 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business u

MOTHER FATHER { 12. Name Lula u
13. Birthplace Fairfield Ill 9
(City, town, or county) (State or foreign country)
14. Maiden name u
15. Birthplace u
(City, town, or county) (State or foreign country)

16. (a) Informant Lula B. Atteberry

(b) Address 202 West 77

17. (a) Removal (b) Date thereof 3-6-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairfield Ill

18. (a) Signature of funeral director P. J. Theissen

(b) Address 2513 Halsted St
19. (a) 3-4-43 (b) M. M. Crow
(Date received local registrar) (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. 419 West 75
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
year 43 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19 _____ to _____ 19 _____
that I last saw him alive on _____ 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular disease of the brain

Due to 12 & B'

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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) _____

(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 R. C. Crow (M. D. or other) 3
Address R. C. Crow Date signed 3/3/43

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, ~~my~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed P. G. Thiesen

Licensed Embalmer No. 2351

P. O. Address 2513 Holman

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.