

FILED JUN 7 1943
Registration District No. **799**

Primary Registration District No. **1002**

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

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. TB Hosp. E.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 m. 29 d.
(Specify whether)

In this community 14 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County JACKSON **48**

(c) City or town KANSAS CITY. **3**
(If outside city or town limits, write "RURAL.")

(d) Street No. 512 E 15th **1**
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: Araube Academia

3. (b) If veteran, name war no

3. (c) Social Security No. 786-76-8374

4. Sex M **4**

5. Color or race Filipino

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

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

7. Birth date of deceased 3 14 1904
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>39</u>	<u>1</u>	<u>26</u>	hr. _____ min.

9. Birthplace Sandayhin Cagayan Philippines
(City, town, or county) (State or foreign country)

10. Usual occupation Hotel - Lobby boy

MOTHER FATHER

11. Industry or business _____

12. Name Eustaquio Academia

13. Birthplace same as (9) **8**
(City, town, or county) (State or foreign country)

14. Maiden name Neasia Hadlus

15. Birthplace same as (9)
(City, town, or county) (State or foreign country)

16. (a) Informant Records K.C. TB Hosp

(b) Address H. C. MO.

17. (a) Burial (b) Date thereof May 19 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary

18. (a) Signature of funeral director A.P. Doshler

(b) Address 1415 East 15th

19. (a) 5-12-43 (b) M. M. Grove
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 10
year 1943 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 12-11-42
19 _____ to 5-10-43 19 _____
that I last saw h. im alive on 5-10-43 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis **6 mo.**
Duration

Due to 1331

Due to Tbc. spine, ribs & chest wall

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury? _____

23. Signature Matthew J. Noon (M. D. or D. O.)
Address _____ Date signed _____

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..... *M. P. Schler*.....

Licensed Embalmer No..... *1166*.....

P. O. Address..... *1415 E 15*.....

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.