

FILED DEC 3 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37540

State File No. _____

Registrar's No. 4866

Registration District No. 1799

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:
1617 Agnes
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 58 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME NELLIE THOMPKINS

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced, wid. 2 divorced Wid.

6. (b) Name of husband or wife Harvey Thompkins

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

7. Birth date of deceased June 3, 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	58	5	10	_____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Frankie Murray

15. Birthplace Lafayette Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Perry Haney

(b) Address 1617 Agnes

17. (a) Burial (b) Date thereof 11/17/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Hutkins Bros

(b) Address 1729 Lydia Avenue

19. (a) 11-17-43 (b) W. E. Brown
(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. 1617 Agnes
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 13, day Saturday
year 1943 hour 10:00 minute A. M.

21. I hereby certify that I attended the deceased from 11-10-1943 to 11-13-1943
that I last saw her alive on 11-12-1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations 83a

Of autopsy and

Duration 3 days.

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)

(c) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 222 E 18 Date signed 11-16-43

F. J. Haegele

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.....

Jerome Munroe

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.