

S. No. 2  
DM-2-43  
5-17-39  
PI X35697

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41347

Registrar's No. 5334

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACKSON  
 (b) City or town K.C.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
UNION STATION 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 hr. (Specify whether years, months or days)

3. (a) PRINT FULL NAME THOMAS WRIGHT WALLER

3. (b) If veteran, name war NO  
 3. (c) Social Security No. 130-09-9624

4. Sex M 5. Color or race C  
 6. (a) Single, widowed, married, divorced MI

6. (b) Name of husband or wife ANITA WALLER  
 6. (c) Age of husband or wife if alive APR 32 years

7. Birth date of deceased MAY 21<sup>P</sup> 1909  
 (Month) (Day) (Year)

8. AGE: Years 39 Months 5x Days x  
 If less than one day hr. min.

9. Birthplace NEW YORK NY  
 (City, town, or county) (State or foreign country)

10. Usual occupation MUSICIAN

11. Industry or business

MOTHER FATHER {  
 12. Name EDWARD WALLER  
 13. Birthplace VIRGINIA VA  
 (City, town, or county) (State or foreign country)  
 14. Maiden name UNKNOWN  
 15. Birthplace UNKNOWN  
 (City, town, or county) (State or foreign country)

16. (a) Informant W. T. (ED) KIRKBY

(b) Address NEW YORK CITY

17. (a) REMOVAL (b) Date thereof 12-16-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N. Y. CITY

18. (a) Signature of funeral director FLENN GREEN STREET

(b) Address K.C. MO.

19. (a) 12-16-43 (b) W. E. Brown  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.Y. (b) County QUEENS  
 (c) City or town JAMAICA L.I.N.Y.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 173-19 SAYRES AVE  
 (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 15  
 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Coroner, 19\_\_\_\_;  
 that I last saw him alive on, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute, influenzal broncho pneumonia

Due to 330

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 W. E. Brown (M. D. or other) \_\_\_\_\_  
 Address K.C. MO. Date signed 12/15/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

130-09-9624

**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 *H. G. Shyrum*

Licensed Embalmer No. 2211

P. O. Address. 1819 E. 15<sup>th</sup> KOK

**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.**