

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 71

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: ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 HOURS
(Specify whether years, months or days)

In this community 3 HOURS

3. (a) PRINT FULL NAME Thompson, JOSEPH ROYCE, JR.

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 SINGLE

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

7. Birth date of deceased JANUARY 5 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. min.

9. Birthplace KANSAS CITY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

11. Industry or business _____

MOTHER FATHER

12. Name JOSEPH ROYCE THOMPSON SR.

13. Birthplace ST. JOSEPH KENTUCKY
(City, town, or county) (State or foreign country)

14. Maiden name MARIE LAPHNE BOWEN

15. Birthplace PIERRE SOUTH DAKOTA
(City, town, or county) (State or foreign country)

16. (a) Informant MR. JOSEPH ROYCE THOMPSON, JR.

(b) Address 7647 WASHINGTON STREET

17. (a) BURIAL (b) Date thereof JAN-6-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director D. H. Newcomer, Sr.

(b) Address 1401 BRUSH CREEK BLYD.

19. (a) 1-6-45 (b) N. 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. 7647 WASHINGTON STREET
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN. day 5TH
year 1945 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 5 1945 to Jan 5 1945
that I last saw him live on Jan 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital polycystic kidneys (Bilateral)

Due to: Congenital ureteral obstruction

Due to: _____

Other conditions: 157 hr
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: as above

Duration _____

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 0

23. Signature Bravie Sherwood (M. D. or dentist) _____
Address Pathologist Date signed 1-5-45

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 *A. C. Newcomer Jr*

Licensed Embalmer No. *4043*

P. O. Address *R. O. M.*

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.