

DECEASED JUN 29 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2542

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: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6-7-45 - 6-12-45
(Specify whether
In this community Unk.
years, months or days)

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. 1002 E. 14
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THOMAS RUSSELL

3. (b) If veteran, name war Unk. 3. (c) Social Security No. None

4. Sex male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased (Month) (Day) (Year) 1882

8. AGE: Years 62 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Unknown

13. Birthplace (City, town, or county) (State or foreign country) Unk. 9

14. Maiden name Unk.

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2.

17. (a) burial (b) Date thereof 6/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem

18. (a) Signature of funeral director Lydia

(b) Address 1729 Lydia

19. (a) 6-14-45 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 12
year 1945 hour 6:10 minute 8. M.

21. I hereby certify that I attended the deceased from June 7 19 45 to June 12 19 45.

that I last saw him alive on June 12 19 45

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration _____

Due to Hypertensive type heart disease

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93 d

Major findings: _____

Of operations _____

Of autopsy as above

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 [Signature] (M. D. or other) _____

Address Gen. Hosp #2-600 6.12 Date signed 6-13-45

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

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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.....

J. Marlowe

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.