

State File No. _____

Registrar's No. _____

FILED JUL 30 1945
799

Registration District No. _____

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: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days (Specify whether
In this community 30 Years years, months or days)

3. (a) PRINT FULL NAME Will Wadon
3. (b) If veteran, name war no
3. (c) Social Security No. None

4. Sex Male **5. Color or race** Wh
6. (a) Name of husband or wife Cara Bell Wadon
6. (c) Age of husband or wife if 72 years
7. Birth date of deceased May 5 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days 9
If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER
12. Name unknown
13. Birthplace unknown
(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 Miss Anna Barkle
(b) Address 8401 General

17. (a) Burial **(b) Date thereof** 7 19 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Quirk & Tobin

(b) Address 20 West Finwood

19. (a) 7-16-45 **(b)** Margeline Holman
(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. 2824 Madison
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1945 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from
July 11 45 to July 14 1945

that I last saw him alive on July 14 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of jaw

Due to _____

Due to _____ 45 d

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 Clark W. Edgerton
Med. I. R. C. General Hospital
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..... *Charles M. Quirk*

Licensed Embalmer No. *3774*

P. O. Address. *2020 Inwood*

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.