

FILED FEB 11 1946
Registration District No. 149

Primary Registration District No. 1002

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 #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 36 years
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. 2425 E. 28th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT
FULL NAME

Cleveland Wallace ~~495-03-7362~~

MEDICAL CERTIFICATION

3. (b) If veteran, name war no
3. (c) Social Security No. 495-03-7362

20. DATE OF DEATH: Month January day 29,
year 1946 hour 11: minute 25 P. M.

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edith Wallace
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased: January 11, 1882
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 25, 1946 to January 29, 1946
that I last saw him alive on January 29, 1946
and that death occurred on the date and hour stated above.
Immediate cause of death. Acute Congestive Failure Duration _____

8. AGE: Years 64 Months 0 Days 18
If less than one day
hr. _____ min. _____

Due to Bronchiectosis

Due to Broncho Carcinoma of Lung

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

10. Usual occupation Janitor

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business None

12. Name Tom Wallace

Major findings: 472
Of operations _____

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

14. Maiden name Rachael Berry

Of autopsy _____

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

16. (a) Informant Medical Records Librarian

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 2-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lenox

18. (a) Signature of funeral director L. B. Watkins

(b) Address 1729 Lyden

19. (a) 1-31-46 (b) Sheldine Holmes
(Date received local registrar) (Registrar's signature)

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 Sheldine Holmes (M. D. or other) _____

Address General Hospital #2 Date signed 1/30/46

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

1309

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. J. Manlove*

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.