

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

2-43
7-39
X35627

FILED FEB 5 1948

State File No. _____

Registration District No. 148

Primary Registration District No. 5568

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Jackson,

(b) City or town Kansas City Rural Blue
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3 blocks East of K. C. on Van Horn Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no.
(Specify whether years, months or days)

In this community unknown
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas

(b) County Wyandotte 994

(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL")

(d) Street No. 1201 Scott Avenue, 0
(If rural, give location)

(e) Citizen of foreign country? no. 2
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Fred Tomerlin

3. (b) If veteran, name war World War #2

3. (c) Social Security No. unknown

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced single 1

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased June 10 1926
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19 1946
year 1946 hour 12:05 minute A M.

21. I hereby certify that I attended the deceased from known 1946 to 1946;
that I last saw him alive on 1946;
and that death occurred on the date and hour stated above.

8. AGE: Years 19 Months 7 Days 8
If less than one day hr. min.

Immediate cause of death Skull fracture

Due to Auto Trauma ✓

Due to _____

9. Birthplace Merriam, Kansas. 1
(City, town, or county) (State or foreign country)

Other conditions Skull fracture

Due to Auto Trauma ✓

Due to _____

10. Usual occupation Sailor, Gunner's Mate

Other conditions Skull fracture

11. Industry or business U. S. Navy

Other conditions Skull fracture

12. Name Henry M. Tomerlin

Other conditions Skull fracture

13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

Other conditions Skull fracture

14. Maiden name Irene Sims

Other conditions Skull fracture

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

Other conditions Skull fracture

16. (a) Informant Mrs. Irene Tomerlin

Other conditions Skull fracture

(b) Address Kansas City, Kansas.

Other conditions Skull fracture

17. (a) removal (b) Date thereof 1-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

Other conditions Skull fracture

(c) Place: burial or cremation Kansas City, Kansas.

Other conditions Skull fracture

18. (a) Signature of funeral director Stine & McClure,

Other conditions Skull fracture

(b) Address 3235 Gillham Plaza, K. C., Mo.

Other conditions Skull fracture

19. (a) 1-19-46 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

Other conditions Skull fracture

20. DATE OF DEATH: Month January day 19 1946
year 1946 hour 12:05 minute A M.

21. I hereby certify that I attended the deceased from known 1946 to 1946;
that I last saw him alive on 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Skull fracture

Due to Auto Trauma ✓

Due to _____

Other conditions Skull fracture

Major findings:
Of operations _____

Of autopsy History & Impression

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 47

(b) Date of occurrence 1-18-46 47

(c) Where did injury occur? Van Horn & Blue Ridge Jackson Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place
(Specify type of place)

While at work? no (e) Means of injury Auto Trauma

23. Signature James W. Ross (M.D. or other) 1-18-46
Address 1424 1/2 N. 1st St. Date signed 1-18-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

6 1946
FEB

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address. MC Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7-26
Registrar's No. 12

Registration District No. 146 Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Blue Jay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME William F. Tomerh

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color w race _____ 6. (a) Single, widowed, married, divorced 3

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

7. Birth date of deceased June 10 1946
(Month) (Day) (Year)

8. AGE: Years 19 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(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 11 Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to Skull Fracture due to Auto Trauma

Due to Fixed object

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

Major findings: Of operations _____

Of autopsy 1700-29 _____

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) accident

(b) Date of occurrence 1-18-46

(c) Where did injury occur? Van Horn & Blue Ridge, Jackson Co Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work? NO (Specify type of place) Auto Trauma
(e) Means of injury _____

23. Signature James C. Walker, Coroner (M. D. or other)

Address 1424 Professional Bldg Date signed 1-10-46

SUPPLEMENTARY

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

1363

2972