

FILED AUG 27 1948
 197

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 No. 10
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **24 days**
(Specify whether years, months or days)
 In this community **38 years**

3. (a) PRINT FULL NAME **James T. Byrnes**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **705-16-1272**

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife **Norma**
6. (c) Age of husband or wife if alive **39 years**
7. Birth date of deceased **August 28 1906**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
39	11	14	hr. _____ min.

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

10. Usual occupation **Taxi driver**

11. Industry or business **Yellow Cab Company**

12. Name **Joseph F. Byrnes Jr.**

13. Birthplace **New York New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Lorella Duggan**

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

16. (a) Informant **Joseph F. Byrnes Jr.**

(b) Address **7341 E. 75th St. K.C. 9MO.**

17. (a) Burial **(b) Date thereof** **8 14 46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Johns, K.C. Mo.**

18. (a) Signature of funeral director **Melvin W. Miller**

(b) Address **1800 E. Lincoln Blvd.**

19. (a) 8-13-46 **(b) Geraldine Holmes**
(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. **3820 Harrison**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **12**
 year **1946** hour **3** minute **20 P.M.**
21. I hereby certify that I attended the deceased from **July 19 1946** to **Aug. 12 1946**
that I last saw him alive on **Aug. 12 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**

Due to _____
 Due to _____

Other conditions **135**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy **None**

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____
23. Signature **Wm W. Hart** (M. D. or other) _____
Address **Med. Dir. Gen'l Hosp.** Date signed **8-13-46**

Dr. Cain

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.....
Licensed Embalmer No.....
P. O. Address.....

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.