

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30495

State File No.

3906

FILED SEP 25 1946
Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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. 1
(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 20 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri (a) State (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1657 Jefferson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles Tignor

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Aug. 10 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 2 If less than one day
hr. _____ min. _____

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

10. Usual occupation None

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 Record Clerk

(b) Address K.C. General Hosp #1

17. (a) Removal (b) Date thereof 9-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary: S.C. Kan.

18. (a) Signature of funeral director Weiler Funeral Home

(b) Address K.C. Mo

19. (a) 9-14-46 (b) Leraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1946 hour 12 minute 25 A.M.

21. I hereby certify that I attended the deceased from
Sept. 8, 1946 to Sept. 12, 1946
that I last saw h. im alive on Sept. 12, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration _____

Due to _____

Due to _____

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

Major findings: 107
Of operations _____

Of autopsy None 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 11

23. Signature Wm W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 9-13-46

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

M. Barry

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..... *Blaine E. Walcott*
Licensed Embalmer No..... *4075*
P. O. Address..... *K.C. 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.