

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

FILED APR 8 1947

Registration District No. **149**

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. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 DAYS** (Specify whether
In this community **30 YRS.** (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **THOMAS EVANS**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **unknown**

4. Sex **MALE** 5. Color or race **NEGRO** 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 **JUNE 27, 1886**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	7	17	hr. min.

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

10. Usual occupation **COMMON LABORER**

11. Industry or business _____

MOTHER FATHER

12. Name **TOM EVANS**

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

14. Maiden name **LINA BANKS**

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

16. (a) Informant **EMMA YOUNG (FRIEND)**

(b) Address **620 CHARLOTTE**

17. (a) **Burial** (b) Date thereof **3-27-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **buried**

18. (a) Signature of funeral director **Wm G. Johnson**

(b) Address **City, Missouri**

19. (a) **3-25-47** (b) **Seraldine 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. **1820 GROVE**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEBRUARY** day **14**,
year **1947** hour **9**: minute **30** P. M.

21. I hereby certify that I attended the deceased from **FEBRUARY 7**, 19 **47** to **FEBRUARY 14**, 19 **47**
that I last saw him alive on **FEBRUARY 14**, 19 **47**; and that death occurred on the date and hour stated above.

Immediate cause of death **LOBAR PNEUMONIA**

Due to _____

Due to _____

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

Major findings: **108**
Of operations _____

Of autopsy _____

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)
(c) Means of injury _____

23. Signature **Frank [Signature]** (M. D. or other) **M.D.**

Address **GENERAL HOSPITAL NO. 2** Date signed **2/15/47**

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Ann A. Schmeyer

Licensed Embalmer No. *2089*

P. O. Address *IT 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.