

Registration District No. 199 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo.
(c) Name of hospital or institution: 1714 Coorington 1
(d) Length of stay: In hospital or institution No (Specify whether years, months or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 1714 Coorington
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Joshua L. PAgET
(b) If veteran, name war. WW I
(c) Social Security No. 496.09.5941

4. Sex Male color race Wh.
5. Color or race Wh.
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife COYA NESSAMAN PAgET
6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased 3 23 1993 (Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days 17 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business Retired

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant Coia PAgET
(b) Address 1714 Coorington

17. (a) Burial, cremation, or removal (b) Date thereof 8-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation TRADING Post HAMS.

18. (a) Signature of funeral director John P. Shield
(b) Address 660 Ms.

19. (a) 8-11-47 (b) Geraldine Holmes (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 8 day 10 year 1947 hour 12 minute 27 P.M.
21. I hereby certify that I attended the deceased from July 30, 1947 to July 26, 1947 that I last saw him alive on July 20, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis pulmonary
Due to _____

Due to _____

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

Major findings: 136
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 R. L. St. Clair (M. D. or other) _____
Address 524 2 St. Paul Date signed Aug 11 47

Duration 24 1/2
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Rev St. Clair 5242 St Jean
Bk. 0141
J.P.M. at Office

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.....

John P. Sheel

Licensed Embalmer No.....

3625

P. O. Address.....

66 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.