

FILED SEP 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30686

State File No. _____

BIRTH NO. 21673-50 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3812

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give town) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 910 Euclid Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) RALPH		b. (Middle) EUGENE		c. (Last) THOMAS		4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 5 1950	
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH MARCH 30 1950	
9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months 5 Days 5		IF UNDER 1 MIN. Hours 5 Min. 5		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KANSAS CITY, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U. S.	

13a. FATHER'S NAME IRA WILLIAM THOMAS		13b. MOTHER'S MAIDEN NAME PATRICIA PAYNE		14. NAME OF HUSBAND OR WIFE —	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME PATRICIA THOMAS		ADDRESS 910 Euclid Avenue	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) UNDETERMINED (n.m.e.)		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				7955	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INFECTION OF SCALP (ETIOLOGY UNDETERMINED)							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I attended the deceased from 8-31, 1950, to 9-5, 1950, that I last saw the deceased alive on 9-5, 1950, and that death occurred at 10:31 P. m., from the causes and on the date stated above.

SIGNATURE Frank Williams MD		23b. ADDRESS 600 East 22nd Street		23c. DATE SIGNED 9-6-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 9-8-1950		24c. NAME OF CEMETERY OR CREMATORY Highland		24d. LOCATION (City, town, or county) (State) Kansas City Mo	
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DATE REC'D BY LOCAL REG. 9-7-50		REGISTRAR'S SIGNATURE Eveline Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Adkins Bros. Funeral Home		ADDRESS K.C. Mo	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Kenneth G. Gersford

Licensed Embalmer No. *44370*

Signed.....
Student Embalmer

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.