

FILED AUG 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27760
Registrar's No. 3413

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3413

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Hickman Mills</u>	
c. LENGTH OF STAY (in this place) <u>5 WKS.</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Kelly Conv Home</u>		e. STREET ADDRESS (If rural, give location) <u>8801 Grace Ave 1</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carlos</u> b. (Middle) <u>Alvey</u> c. (Last) <u>Thomas</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-16-54</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>2-15-1875</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Platt Co. Kans</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>William Thomas</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Jane Reed</u>		14. NAME OF HUSBAND OR WIFE <u>Susie C Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Robert O. Wilson</u>		ADDRESS <u>3904 R. 2nd St. Platt Co. Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Senile</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>-</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u>		<u>20 yrs</u>	
<u>33/4</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>54</u> , to <u>June 19</u> 19 <u>54</u> , that I last saw the deceased alive on <u>June 19</u> , 19 <u>54</u> and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>L. E. Riller MD</u> (Degree or title)		23b. ADDRESS <u>K.C., Mo</u>	
23c. DATE SIGNED <u>7/6/54</u>		24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>7-17-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
24d. LOCATION (City, town, or county) <u>Independence Mo</u> (State) _____		DATE REC'D BY LOCAL REG. <u>7-16-54</u>	
REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Shil</u> ADDRESS <u>K.C. Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD I. E. Riller MD

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John P. Shield*.....

Licensed Embalmer No. *362*

P. O. Address *K C O*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.