

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

x FILED VS JUL 31 1959

59-025471

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3453 STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in <u>6 weeks</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>27th & Troost - On street</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1001 E. 26th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LUTHER</u> Middle <u>T</u> Last <u>THOMPSON</u>			4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1937</u>	9. AGE (last birthday) <u>22</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (City and state or country) <u>Suffolk, Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Haywood Thompson</u>	13b. MOTHER'S MAIDEN NAME <u>Rosetta Stallings</u>	14. NAME OF HUSBAND OR WIFE <u> </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> </u>	17. INFORMANT <u>Haywood Thompson; Suffolk, Va.</u>	Address <u> </u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u>Multiple Automobile Trauma</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Auto trauma</u>
20c. TIME OF INJURY Hour <u>1:25</u> a.m. <u> </u> Month, Day, Year <u>July 14, 1959</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>27th & Spruce</u>	20f. CITY, TOWN, OR LOCATION <u>Kansas City, Jackson, Mo.</u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u> </u> to <u> </u> and last saw her/him live on <u> </u> . Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Wm. Tillman M.D.</u>		22b. ADDRESS <u>1618 Lydia Ave</u>	22c. DATE SIGNED <u>7/14/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>July 15, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u> </u>	23d. LOCATION (City, town, or county) (State) <u>Suffolk, Virginia</u>
24. FUNERAL DIRECTOR <u>Brown-Hudson K.C., Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-14-59</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

M. TILLMAN

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.