

FILED APR 12 1940

1002

Registrar's No. **1068**

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo**
(c) Name of hospital or institution: **Gen Hosp # 2 K.C. Mo**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **about 10 hrs**
(Specify whether
In this community **2 years.**
years, months or days)

3. (a) PRINT FULL NAME **EMERLE WASHINGTON**

3. (b) If veteran, **no** name war. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife **single** 6. (c) Age of husband or wife if alive **4** years
7. Birth date of deceased **Mar 4 1920**
(Month) (Day) (Year)

8. AGE: Years **20 0** Months **11** Days **27** If less than one day hr. min.

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

10. Usual occupation **Delivery Boy**

11. Industry or business **Drug Store**

MOTHER FATHER
12. Name **U. L. Washington**
13. Birthplace **Kingfisher Okla**
(City, town, or county) (State or foreign country)
14. Maiden name **Went Knorr**
15. Birthplace **West Knorr**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **U. L. Washington**

(b) Address **119 W. 13th Des Moines Iowa**

17. (a) **Burial** (b) Date thereof **3-6-40**
(Specify type of place) (Month) (Day) (Year)

(c) Place: burial or cremation **C. U. O**

18. (a) Signature of funeral director **Fleming Brechtel**

(b) Address **1819 E. 15th K.C. Mo**

19. (a) **Mar 7, 1940** (b) **M. M. Crome**
(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. **1701 East 12th**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **1** - **40**
year _____ hour _____ minute **3:20 A.M.**

21. I hereby certify that I attended the deceased from _____ to _____ 19____;
that I last saw him/her on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Subacute & Subchronic Hemorrhage**
Duration _____

Due to **Thrombocytopenic Purpura**
Due to _____

Other conditions **21000-1**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **2-25-40**

(c) Where did injury occur **Passing on 7th**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While on bicycle when struck by car

(Specify type of place) (e) Means of injury _____

23. Signature **Quellwitzer** (M. D. or other) _____
Address _____ Date signed _____

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X18511

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 Edw. Stevens

Licensed Embalmer No. 2836

P. O. Address 1819 E. 15th 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, above space should be left blank.