

3. No. 2
-11-10-39
5-17-39
P1 X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20793**
Registrar's No. **2410**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
582 Troost
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 Yrs.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Albert Thomas 520**

8. (b) If veteran, name war **No** 8. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Cod.** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **--** 6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **June 20, 1889**
(Month) (Day) (Year)

8. AGE: Years **51** Months **11** Days **18** If less than one day hr. min.

9. Birthplace **Lafayette Co., Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business

12. Name **Albert Thomas**

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

14. Maiden name **Jennie Nerves**

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

16. (a) Informant **Mary Johnson**

(b) Address **1412 Cypress**

17. (a) **Burial** (b) Date thereof **6-29-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cem.**

18. (a) Signature of funeral director **Irving + Brady**

(b) Address **1513 Troost**

19. (a) **June 12, 1940** (b) **M. M. Crowe**
(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. **2048 Holmes**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6-2-40**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ Co. _____ 19____;
that **Opusky Crowe** gave birth to the deceased on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Edema**

Due to **Whitney Edema (Hemorrhage)**

Due to **Do not know**

Other conditions (Include pregnancy within 3 months of death) **111B**

Major findings: 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 **5**

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

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

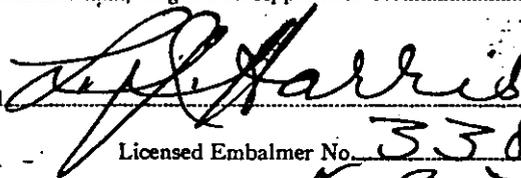
MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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



Licensed Embalmer No.

3388

P. O. Address

K.C., 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.

The term
Pulmonary ^{Purste} hemorrhage

is used in the
same sense as
Pulmonary Congestion