

FILED JUL 9 1943 99
Registration District No.

Primary Registration District No. 1002

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

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: 1021 Tracy
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

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.: 1021 Tracy
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: Thomas W. Harrison

3. (b) If veteran, name war: None

3. (c) Social Security No. _____

4. Sex: Male

5. Color or race: Col

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: April 16
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Paper Hanger

11. Industry or business: _____

12. Name of father: Smith Harrison

13. Birthplace: Missouri
(State or foreign country)

14. Maiden name: Spicer Harvey
(State or foreign country)

15. Birthplace: Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant: Madeline Harrison

(b) Address: 1021 Tracy

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director: Hatchins Bros.

(b) Address: 1729 Lydia

19. (a) 6-30-42 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 20-42
year _____ hour _____ minute 10 A.M.

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

Signature: Deputy Coroner

Immediate cause of death: Bilateral Hydrothorax

Due to: Primary Aortic Aneurysm

Due to: Sclerotic Aortitis

Other conditions (Include pregnancy within 3 months of death): gta

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)

(e) Means of injury: _____

23. Signature: [Signature] (M. D. or other) _____

Address: [Address] Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

177017 2000/11

801

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 *Gene Manlove*

: Licensed Embalmer No. *3994*

: P. O. Address *2503 Highland*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20293
Registrar's No. 2450

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Thomas W. Harrison

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased: April 16 1942
(Month) (Day) (Year)

8. AGE: 43 Years 2 Months 4 Days (If less than one day, hr., min.)

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

10. Usual occupation

11. Industry of business

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9/14/42 (Date received local registrar) (b) J. S. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 16 Year 1942 hour 10 minute 30 M.

21. I hereby certify that I attended the deceased from 9 to 10, 19...; that I saw him alive on 4/16, 19...; and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN

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).....

(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) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

