

Registration District No. **49**

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:  
Little Sisters of the Poor **5**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 days 5 mo. (Specify whether years, months or days)

In this community 14 years 5 months

3. (a) PRINT FULL NAME THOMAS COULTAS

(b) If veteran, name war No Record

(c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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 October 31 1854  
(Month) (Day) (Year)

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

88 4 13 12 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER

12. Name Thomas J. Coultas

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

14. Maiden name Anne Elizabeth Carney **9**

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

16. (a) Informant Dr. St. Thule

(b) Address 5331 Highland

17. (a) Burial (b) Date thereof 3-18-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quirk and Poling Co.

(b) Address 20 West Linwood

19. (a) 3/16/43 (b) M. M. Crome  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **48**

(a) State Missouri (b) County Jackson **3**

(c) City or town Kansas City **8**  
(If outside city or town limits, write "RURAL")

(d) Street No. 5331 Highland  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) **0**  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13th  
year 1943 hour Three minute 25 P.M.

21. I hereby certify that I attended the deceased from Feb. 24  
1943, to March 11, 1943  
that I last saw him alive on March 11, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Thrombosis **3 da**

Due to Myocardiosis **40 yrs.**

Due to Arteriosclerosis **hrs.**

Other conditions (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) \_\_\_\_\_

(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 John P. Skinner (M. D. or other) **9**

Address Bryant Bldg. X.C. Date signed 3-16-43

**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.....

P. O. Address.....

**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, fact should be so stated above.**