

**FILED MAY 3 1943 149**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1002**

Registrar's No. **1738**

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 **Lakeside Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **Two & one-half** hours  
(Specify whether hours, days, weeks, months, or years)

In this community **40 Years**  
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. **2620 Wabash Avenue**  
(If rural, give location)

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

3. (a) PRINT FULL NAME **Quincy Alfred Thomson**

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

3. (c) Social Security No. **None**

4. Sex **M**

5. Color or Race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **May Thomson**

6. (c) Age of husband or wife if alive **77** years

7. Birth date of deceased **January 12 1862**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>81</b>	<b>2</b>	<b>25</b>	<b>24</b> hr. min.

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

10. Usual occupation **Retired 12 Years**

11. Industry or business **Postal Clerk**

MOTHER FATHER {

12. Name **Quincy Thomson**

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

14. Maiden name **Flora McDaniel**

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

16. (a) Informant **Mrs. May Thomson**

(b) Address **2629 Wabash Avenue**

17. (a) **Burial** (b) Date thereof **April 9, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Slater, Missouri**

18. (a) Signature of funeral director **S. H. Newcomb**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **4-9-43** (b) **M. M. Crowe**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **6th**  
year **1943** hour **12:30 P.M.** minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **3/24** to **4/6**  
that I last saw him alive on **Apr. 6**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**

Due to **108**

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)

(c) Means of injury \_\_\_\_\_

23. Signature **Dr. E. H. Bird** (M.D. or other) **D.O.**  
Address **2645 Wabash** Date signed **4/7/43**

**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..... *Emile M. Calhoun*.....  
Licensed Embalmer No. *3506*.....  
P. O. Address..... *← cmo*.....

**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.**