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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

LED MAY 6 1948
Registration District No. 149

Primary Registration District No. 1002

1892

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3207 Anderson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 71 years
years, months or days)

3. (a) PRINT FULL NAME Granville C Tomlinson

3. (b) If veteran, name war No

3. (c) Social Security No. No

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

6. (b) Name of husband or wife Lena May Shelton Tomlinson live 52 years

6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Dec. 1, 1871
(Month) (Day) (Year)

8. AGE: Years 71 Months 4 Days 19 If less than one day
hr. _____ min.

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

10. Usual occupation Retired Minister

11. Industry or business _____

MOTHER FATHER { 12. Name David P. Tomlinson

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

14. Maiden name Martha Nichols

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

16. (a) Informant Mrs. Lena May Tomlinson

(b) Address 3207 Anderson, K.C. Mo.

17. (a) Burial (b) Date thereof Apr. 22-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Washington Cem.

18. (a) Signature of funeral director Sheil Funeral Home

(b) Address 6606 Indep. Ave. K.C. Mo.

19. (a) 4-21-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 78

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 3207 Anderson
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1943 hour 4 minute 43 A.M.

21. I hereby certify that I attended the deceased from April 21, 1943
19____ to April 20, 1943
that I last saw him alive on April 15, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 1 1/2 days

Due to Arterial hypertension 5 yrs

Due to 83a

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 W. Wall (M. D. or other) _____
Address 3236 Woodchase Ave Date signed 4/20/43

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

Dr. Wall 5236 Winsor

B 2 0 1 0 1 7 o'clock tonight

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 John P. Shield

Licensed Embalmer No. 3625

P. O. Address K B M

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.