

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County: KANSAS
(b) City or town: JACKSON
(c) Name of hospital or institution: 900 E 163rd
(d) Length of stay: In hospital or institution: 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: JACKSON
(c) City or town: KANSAS CITY
(d) Street No.: 7615 Holmes
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME: THUDION - PARK A.

MEDICAL CERTIFICATION

3. (b) If veteran, name war: NO 3. (c) Social Security No. *uninsured*

20. DATE OF DEATH: Month 8 day 4 year 43 hour 3:45 minute P.M.

4. Sex: MASC Race: *wh* 5. (a) Color of hair: *brn* 6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: MRS. VELLIE THUDION 6. (c) Age of husband or wife if alive: 53 years
7. Birth date of deceased: (Month) FEB (Day) 27 (Year) 1887

21. I hereby certify that I attended the deceased from *Arrival* 19*43* to *8* 19*43* that I last saw him alive on *8* 19*43* and that death occurred on the date and hour stated above.

8. AGE: 56 years 5 Months 8 Days If less than one day hr. min.

Immediate cause of death: *Artery atherosclerosis*

9. Birthplace: St Catherine MO (City, town, or county) (State or foreign country)

Due to: *94a*

10. Usual occupation: *Service*

Due to: ~~_____~~

11. Industry or business: *Station Dealer*

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

12. Name: *John Thudion*

Major findings: ~~_____~~

13. Birthplace: *St Catherine MO* (City, town, or county) (State or foreign country)

Of operations: ~~_____~~

14. Maiden name: *John McCallister*

Of autopsy: *See above*

15. Birthplace: *St Catherine MO* (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant: *Mrs Carl Thudion* (b) Address: *7615 Holmes*

(a) Accident, suicide, or homicide (specify): ~~_____~~

17. (a) *Burial* (b) Date thereof: *8-9-43* (c) Place: burial or cremation: *Memorial Park*

(b) Date of occurrence: ~~_____~~

18. (a) Signature of funeral director: *Juddeleuth* (b) Address: *16 E. 11th*

(c) Where did injury occur? ~~_____~~ (City or town) (County) (State)

19. (a) *8-7-43* (b) *Dep. J. E. Brown* (Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ~~_____~~ (Specify type of place)

While at work? *CVT* (Specify type of place) (a) Means of injury: *8/7/43*
23. Signature: *CVT* (M. E. of physician) Date signed: *8/7/43*

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

MOTHER FATHER

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.