

FILED AUG 21 1949 149

Registration District No. _____

Primary Registration District No. 100.2

Registrar's No. _____

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: R.C. TB Hosp.
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 8 m 4 d (Specify whether _____)
In this community 50 yrs. (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. 2444 Washington
(If rural, give location)

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

3. (a) PRINT FULL NAME Frank Thompson

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. 496-05-1855

4. Sex M 5. Color or face W

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

6. (b) Name of husband or wife Wira

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased 11 19 1877
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Truck Driver

11. Industry or business coal

12. Name unknown

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 Reeds R.C. TB Hosp.

(b) Address Reeds St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 43
(Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill

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

(b) Address Rt. 6, Mo

19. (a) 8-14-43 (Date received local registrar) (b) D.E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14
year 1943 hour 5:30 minute A M.

21. I hereby certify that I attended the deceased from 12-10-42
to 8-14-43
that I last saw h.t.m. alive on 8-14-43
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to 1361

Other conditions Tuberculosis Epididymitis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy Pulmonary Embolus Left TB prostate Left testicle

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? _____

23. Signature Matthew J. Noon (Specify type of place) (Means of injury) _____
Address Reeds St. Date signed 8/14/43

Duration 4 1/2 yrs

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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: *A. R. Hainschild*

Licensed Embalmer No. *4159*

P. O. Address: *Kansas City, Mo.*

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.