

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20905

State File No. \_\_\_\_\_

Registration District No. 8/1922

Primary Registration District No. 1002

Registrar's No. 2653

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:  
K.C. General Hospital # 1  
(If not in hospital or institution, write street number and location)  
 (d) Length of stay: In hospital or institution 12 days  
(Specify whether years, months or days)  
 In this community 25 YEARS

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri County Jackson  
 (b) City or town Kansas city  
(If outside city or town limits, write "RURAL")  
 (c) Street No. 1421 Charlotte  
(If rural, give location)  
 (d) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Vlohev Thomas  
 3. (b) If veteran, name war unknown  
 3. (c) Social Security No. unknown

MEDICAL CERTIFICATION 835  
 20. DATE OF DEATH: Month June day 23  
 year 1944 hour 8 minute 35 A.M.  
 21. I hereby certify that I attended the deceased from June 11, 1944 to June 23, 1944  
 that I last saw him alive on June 23, 1944  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced unknown  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death \_\_\_\_\_  
Bronchogenic carcinoma with metastasis to brain.

7. Birth date of deceased Dec 21 1879  
(Month) (Day) (Year)  
 8. AGE: Years 64 Months 6 Days 2  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace unknown (State or foreign country) 9  
 10. Usual occupation Dishwasher

Major findings: Of operations 49  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
 12. Name unknown  
 13. Birthplace unknown (State or foreign country) 9  
 14. Maiden name unknown  
 15. Birthplace unknown (State or foreign country) 9

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? \_\_\_\_\_

16. (a) Informant Hospital Records  
 (b) Address K.C. mo  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26, 1944  
(Month) (Day) (Year)  
 (c) Place: burial or cremation WOODLAWN CEMETERY - INDEPENDENCE, MO

While at work (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_  
 23. Signature A. E. Upsher (M. D. or other) mo  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

18. (a) Signature of funeral director George M. Collier  
 (b) Address 11103 Wenden Rd. Independence Mo  
 19. (a) 6-24-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

DEPARTMENT OF HEALTH  
BUREAU OF HEALTH  
V.S. No. 2  
100M-8-43  
Rev. 5-17-39

**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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address Independence

**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.**