

FILED JAN 11 1945

State File No. _____

5354

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C. Mo.
(c) Name of hospital or institution 1719 W. 9th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours
In this community 2 hours
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(d) Street No. R.R. #3 K.C. Kans. 14
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Henry Tankins

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race negro 6. (a) Single, widowed, married divorced married
6. (b) Name of husband or wife Mary Tankins 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Unknown

8. AGE: Years Months Days If less than one day
about 61 - - - hr. min.

9. Birthplace Kansas

10. Usual occupation Comm. Laborer

11. Industry or business _____

MOTHER FATHER
12. Name Daniel Rankins
13. Birthplace Unknown
14. Maiden name Unknown
15. Birthplace Unknown

16. (a) Informant Mary Rankins
(b) Address R.R. #3 K.C. Kans.

17. (a) Burial (b) Date thereof 12-31-44

(c) Place: burial or cremation Old Standard
18. (e) Signature of funeral director Mrs. J. W. Jones

(b) Address 440 State Ave. K.C. Kans.

19. (a) 12-30-44 (b) D.E. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 23
year 1944 hour 12:42 minute P.M.

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

Immediate cause of death
Parasitic Dilatation

Due to Colicula Disease

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings: History & Inspection
Of operations _____
Of autopsy not

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? _____
(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 J. W. Jones (M. D. or other)
Address 1424 Jefferson Ave. Date signed 12-23-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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. T. Moore
Licensed Embalmer No. 948
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.