No. 2
M—2-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 11 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10386
Registrar's No. 5270

Registration District No. 149 Primary Registration District No. 1002

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 No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos. 15 days (Specify whether years, months or days)
In this community 20 Years

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. 1406 Troost
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Samuel E. Thomas
3. (b) If veteran, name war No
3. (c) Social Security No. 466-07-7496
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alicia Thomas
6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased 8 (Month) 22 (Day) 1900 (Year)

8. AGE: Years	Months	Days	If less than one day
44	4	1	hr. min.

9. Birthplace Nebraska (City, town, or county) (State or foreign country)
10. Usual occupation Salesman
11. Industry or business Sinclair Oil Company
FATHER 12. Name Samuel Thomas
13. Birthplace Nebraska (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Lillie English
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Alicia Thomas
(b) Address 1406 Troost
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill
18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address Kansas City, Missouri
19. (a) 12-26-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 23 year 1944 hour 9 minute 35 A. M.
21. I hereby certify that I attended the deceased from August 8 1944 to Dec. 23 1944; that I last saw him alive on Dec. 23 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy See above	

PHYSICIAN — 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? (Specify type of place)
While at work (e) Means of injury

23. Signature A. E. Usher (M. D.)
Address Med. Dir. Gen'l Hosp. Date signed 12-25-44

(Licensed Embalmer's Statement on Reverse Side)

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. 35-99

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.