No. 2
-2-43
-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 6 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1470

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 262

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. TB. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 9 days. (Specify whether
In this community 16 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 6906 Walrond Avenue
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country ----- 11

3. (a) PRINT FULL NAME Roy G Sykes, Sr.

3. (b) If veteran, name war No.

3. (c) Social Security No. 490-10-5060

4. Sex Male

5. Color or race White

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

6. (b) Name ~~of husband~~ or wife Ollie J Sykes

6. (c) Age ~~of husband~~ or wife if alive 36 years

7. Birth date of deceased 3 (Month) 7 (Day) 1907 (Year)

8. AGE: Years 37 | Months 10 | Days 10 | If less than one day ___ hr. ___ min.

9. Birthplace Benson (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Inspector

11. Industry or business Water Dept K.C. Mo.

FATHER
12. Name Clarence Sykes
13. Birthplace UNKNOWN. (City, town, or county) KANSAS (State or foreign country)

MOTHER
14. Maiden name Grace Ewing
15. Birthplace UNKNOWN (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Records K.C. TB. Hosp.

(b) Address KC 3 Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN-20-1945 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ GREEN LAWN CEM.

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401-BRUSH CREEK-K.C. MO.

19. (a) 1-17-45 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17
year 1945 hour 10-30 minute A. M.

21. I hereby certify that I attended the deceased from 1-8-45, 19__, to 1-17, 1945;
that I last saw him alive on 1-17, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Tuberculosis of Kidney	6 yrs.
Due to	
Due to 13 b'	
Other conditions Tuberculosis Pulmonary (Include pregnancy within 3 months of death)	?

Major findings:
Of operations

Of autopsy T.B. Kidney left; TB. Bladder; Pulmonary TB. TB. Peritonitis

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 0

23. Signature Matthew J. Noon (M. D. ~~or other~~)

Address K.C. 3 Mo. Date signed 1/17/44

(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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.