

FILED APR 5 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1264

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:
Home - 2415 Poplar Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 23 Years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Thomas Jackson

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Elizabeth Jackson
6. (c) Age of husband or wife if alive Deceased
7. Birth date of deceased May 11th, 1854
(Month) (Day) (Year)

8. AGE: Years 90 Months 8/10 Days 6
If less than one day hr. min.

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

10. Usual occupation Saw Mill Operator

11. Industry or business For Self

12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Jackson

(b) Address 2415 Poplar Ave.

17. (a) Burial (b) Date thereof 3/13/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cem.

18. (a) Signature of funeral director Earp Funeral Home

(b) Address 4139 East 15th, St.

19. (a) 3-19-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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. 2415 Poplar Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17th,
year 1945 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from Jan 10
1945 to Mar 17 1945
that I last saw him alive on Mar 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia
Duration gender

Due to semiticity
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108
Of autopsy

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?

While at work? (Specify type of place) (c) Means of Injury.....
23. Signature Herrington (M. D. or other) M.D.
Address 1014 Argyle Bldg Date signed 3/19/45

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

19
38

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

John B. Camp

Licensed Embalmer No. *29155*

P. O. Address *14 C. 9th*

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.