

FILED MAR 24 1945

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 1091

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

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:  
Wheatley Provident Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2/23 to 3/4  
(Specify whether  
In this community 63 years  
years, months or days)

3. (a) PRINT FULL NAME Elmer King

3. (b) If veteran, name war None  
3. (c) Social Security No. 493-12-5635

4. Sex Male 5. Color or race Col  
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown 1881  
(Month) (Day) (Year)

8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Janitor

11. Industry or business \_\_\_\_\_

MOTHER FATHER

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 Belle Booze

(b) Address 1507 Harrison

17. (a) burial (b) Date thereof 3/8/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Hatkins Bros.

(b) Address 1729 Lydia

19. (a) 3-8-45 (b) N. 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. 1507 Harrison  
(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 4th  
year 1945 hour 4 minute A. M.

21. I hereby certify that I attended the deceased from 2 to 24  
24 1945 to 3-4 1945  
that I last saw him alive on 3-4 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death 1) Intestinal Obstruction  
2) Impacted feces  
3) Tapermia  
Duration \_\_\_\_\_  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Distended Intestines (Gas + Feces)  
Of operations \_\_\_\_\_  
Of autopsy none

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)  
(a) Means of injury 0  
23. Signature [Signature] (M. D. or other) M.D.  
Address 1618 Lydia Date signed 3/8/45

*Tillman*

**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.....

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.**