

S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36871

FILED MAY 15 1945  
1949

Registration District No. 1999

Primary Registration District No. 1002

Registrar's No. 1981

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution May 1-45 May 9-45  
(Specify whether)

In this community do not know  
years, months or days

3. (a) PRINT FULL NAME Joseph Cole

3. (b) If veteran, name war Do not know

3. (c) Social Security No. none

4. Sex Male 5. Color or White

6. (a) Single, widowed, married, divorced  
6. (c) Age of husband or wife if Do not know

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Do not know 9  
(City, town, or county) (State or foreign country)

10. Usual occupation none

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

MOTHER FATHER

12. Name Do

13. Birthplace Do not know 9  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace Do not know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Coroner office

(b) Address Kansas city mo

17. (a) School (b) Date thereof May 8, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: St. Challege & Dwyer St. Sugar

18. (a) Signature of funeral director Passant, Bros

(b) Address Kansas city mo

19. (a) 5-5-45 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Jackson 49

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

(d) Street No. 548 Main 5  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4  
year 1945 hour 12 minute 15 A M.

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

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 830  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy No permit  
Whitely & Inspecter

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)

(e) Means of injury \_\_\_\_\_

23. Signature James Walker 3  
(M.D. or other)

Address 1424 Pine St Date signed 5-5-45

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**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..... *Francis Walter* .....

Licensed Embalmer No *2744* .....

P. O. Address..... *19 C mo* .....

**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.**