

FILED JUL 20 1945

Registrar's No. **2987**

Registration District No.

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: Kansas City Tuberculosis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether
In this community 13 years
years, months or days)

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. 2003 N. 4th
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

JOHN NOLEN

3. (b) If veteran,

name war no

3. (c) Social Security

No. none

4. Sex MALE

5. Color or race COLORED

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 4 1912
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>3</u>	<u>10</u>	hr. min.

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

10. Usual occupation none

11. Industry or business

MOTHER FATHER

12. Name Phil Nolen

13. Birthplace ARKANSAS
(City, town, or county) (State or foreign country)

14. Maiden name Rena

15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Kansas City Tuberculosis Hospital
(b) Address Kansas City, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-45
(Month) (Day) (Year)

(c) Place: burial or cremation Springfield

18. (a) Signature of funeral director W. L. Coffman

(b) Address N. C. Mo.

19. (a) 7-17-45 (Date received local registrar) (b) Waldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1945 hour 10 minute 45 PM.
21. I hereby certify that I attended the deceased from July 17
19 45 to July 14 19 45
that I last saw him alive on July 14
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Duration 5 yrs
Due to 13 yrs
Other conditions Rectal pituitary adenoma 1945
(Include pregnancy within 3 months of death)

Major findings:
Of operations
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) (e) Means of injury

23. Signature W. L. Coffman (M. D. or other) M.D.
Address Kansas City Mo. Date signed 7-15-45

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

18
3
8

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 W. G. Flynn

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th KO2

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.