

FILED OCT 29 1945
149

Registration District No. _____

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **Feeds Tuberculosis Hosp.**
(d) Length of stay: In hospital or institution **10 days**
In this community **30 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **2450 Bellevue**
(e) Citizen of foreign country? **Yes**
If yes, name country **Mexico**

3. (a) PRINT FULL NAME

Eusebio Hernandez

3. (b) If veteran, name war

N.

3. (c) Social Security No.

None

4. Sex **Male**

5. Color or race **Mex**

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

6. (b) Name of husband or wife **Refugia**

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

7. Birth date of deceased **Dec. 19 1888**

8. AGE: Years **56** Months **9** Days **27**
If less than one day hr. min.

9. Birthplace **Agua Calientes Mexico**

10. Usual occupation **unemployed**

11. Industry or business

MOTHER FATHER {
12. Name **Hernandez**
13. Birthplace **unknown**
14. Maiden name **Refugia**
15. Birthplace **unknown**

16. (a) Informant **Feeds Tuberculosis Hosp.**
(b) Address **Feeds, Mo.**

17. (a) **Burial** (b) Date thereof **10-16-45**

(c) Place: burial or cremation **St. Marys Cemetery**

18. (a) Signature of funeral director **Weilert Funeral Home**

(b) Address **2332 Monitor Place, K.C. Mo.**

19. (a) **10-15-45** (b) **Cheradine Holmes**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **13**
year **1945** hour **6** minute **2** M.
21. I hereby certify that I attended the deceased from **October 3**
19**45**, to **October 13** 19**45**

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**
Duration **6 mo**

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **13th**

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? _____
(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 _____
Signature **D. L. Coffman** (M. D. or other) **MD**
Address **Lawrence City Mo** Date signed **10-13-45**

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

8
3
8

NOV 9 1945

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..... *Blaine E. Weichert*
Licensed Embalmer No..... *4075*
P. O. Address..... *K.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.