

FILED JAN 4 9 1948

Registration District No. _____

Primary Registration District No. 1002

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: 709 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town Kansas City MO
(If outside city or town limits, write "RURAL")
(d) Street No. 709 Washington
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Thomas Kirkman

3. (b) If veteran, name war NO 3. (c) Social Security No. Don't know

4. Male 5. Color or race White 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
(Month) (Day) (Year)

8. AGE: Years 80 Months _____ Days _____ If less than one day
hr. _____ min. _____

9. Birthplace Don't know
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER
12. Name Thomas Kirkman
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann Jackson
15. Birthplace Jackson
(City, town, or county) (State or foreign country)

16. (a) Informant Career officer
(b) Address R.C.M.

17. (a) School (b) Date thereof Dec 22-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial St. Callixtus Cemetery

18. (a) Signature of funeral director Richard B. B...

(b) Address _____

19. (a) 12-22-45 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1945 hour 11 minute 10 A.M.

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

Immediate cause of death coronary sclerosis
Due to status epilepticus
Date Dec 17 1945

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

Major findings: Of operations 94 a
Of autopsy and post mortem
 History & Inspection

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?
 Yes at work (Specify type of place) (e) Means of injury _____

23. Signature James ... (M. D. or other) _____
Address 1824 ... Date signed 12-17-45

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 Waller*

Licensed Embalmer No. *2744*

P. O. Address..... *15 C M*

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.