

FILED FEB 27 1946

Registration District No. 2497

Primary Registration District No. 1002

Registrar's No. **357**

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: General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community 8 years
year, months or days)

3. (a) PRINT FULL NAME Thomas Melton

3. (b) If veteran, name war no
3. (c) Social Security No. no

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

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 19:37 years

7. Birth date of deceased: August (Month) 1 (Day) 19:37 (Year)

8. AGE: Years 8 Months 5 Days 17
If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business None

12. Name Thomas Melton

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

14. Maiden name Eola Boggs

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

16. (a) Informant Medical Records Librarian

(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-46 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Home

18. (a) Signature of funeral director Miss J. W. Jones

(b) Address 440 State Ave. S. E. Okla

19. (a) 1-23-46 (Date received local registrar) (b) Sheldene Holmes (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. 2442 Flora (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18, year 1946 hour 12: minute 15 P. M.

21. I hereby certify that I attended the deceased from January 6, 1946 January 18, 1946; that I last saw him alive on January 18, 1946; and that death occurred on the date and hour stated above. Immediate cause of death Acute Peritonitis

Due to Ruptured Appendix

Due to

Other conditions (Include pregnancy within 3 months of death) 12-11

Major findings: Ruptured suppurative appendicitis
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 cause of injury)

23. Signature J. O. Turner (M. D. or other)

Address General Hospital #2 Date signed 1/19/46

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

1129

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..... *Eugene English*

Licensed Embalmer No. *44005*

P. O. Address. *440 State Ave.*

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.