

S. No. 2
5-17-39
X39697

FILED JAN 31 1946

Registration District No. 149

Primary Registration District No. 1002

State File No. 273
Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution 4 years - 6 months
(If in this community, years, months or days) (3 yrs) city whether

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 7 1/2 East 8th St
(If rural, give location)

(e) Citizen of foreign country? No
If yes, name country

3. (a) PRINT FULL NAME MARK WAYBRIGHT (alias) PARKER, ALBERT

3. (b) If veteran, name war NO

3. (c) Social Security No. 494-12496

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15
year 46 hour 6 minute 50 P.M.

21. I hereby certify that I attended the deceased from 7-26-41 1941 to 1-15-46 1946
that I last saw him alive on 1-15-46 1946
and that death occurred on the date and hour stated above.

4. Sex M 0 5. Color or race W

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

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive 4 years 1984 (Day) (Year)

7. Birth date of deceased: Feb (Month) 4 (Day) 1884 (Year)

Immediate cause of death Pulmonary Tuberculosis 7 yrs

Due to

Due to

8. AGE: Years 61 Months 11 Days 11 If less than one day hr. min.

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

Other conditions (Include pregnancy within 3 months of death)

Of operations 13

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

10. Usual occupation shingler

11. Industry or business

12. Name James S. Parker Waybright

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

14. Maiden name Josephine Hayes

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

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?

16. (a) Informant KCTB Hospital

(b) Address Kansas cy Mo

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

(c) Place: burial or cremation St. Louis, Missouri

18. (a) Signature of funeral director Wm. H. Foster

(b) Address 918 Franklin St. St. Louis

19. (a) 1-17-46 (b) Gerardine Holmes
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place)

(e) Means of injury

23. Signature A. L. Coffman (M.D. or other) MD
Address Kansas City Mo Date signed 1-16-46

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

1170

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..... *Cortland Minor*

Licensed Embalmer No. *3414*

P. O. Address *918 Brooklyn*

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.