

FILED MAY 7 1948

Registration District No. **149**

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:  
**3229 E 7th St., /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **no** (Specify whether)  
In this community **12 yrs**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3229 E 7th St.,**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country.

3. (a) PRINT FULL NAME **WILLIAM LEVI THRAILKILL, M. D.**

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

4. Sex **Male** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Louise King Thraikill** 6. (c) Age of husband or wife if alive **42** years  
7. Birth date of deceased **1/13/1884**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**64** **3** **6** hr. min.

9. Birthplace **Caldwell, Kans.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Physician**

11. Industry or business **Self**

12. Name **Levi Thraikill**  
13. Birthplace **Unk.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Atteberry**  
15. Birthplace **No record**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Louise Thraikill**

(b) Address **3229 E 7th St.,**

17. (a) **Burial** (b) Date thereof **4/21/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **St Joseph, Mo.**

18. (a) Signature of funeral director **John P. Sheil**

(b) Address **Kansas City, Mo.**

19. (a) **4-21-48** (b) **A. Thraikill**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **19**  
year **1948** hour **11** minute **45** A. M.

21. I hereby certify that I attended the deceased from **1940** to **April 19, 1948**  
that I last saw him alive on **April 19, 1948**  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Diabetes Mellitus**  
Duration **Years**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (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 **E. D. Reese** (M. D. or other) \_\_\_\_\_  
Address **3309 E 12** Date signed **4-20-48**

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

MOTHER FATHER

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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.....

*Charles Mayfield #18*, Registered Apprentice No.....  
working under my personal supervision.

Signed *John P. Shiel*.....

Licensed Embalmer No. *36287*.....

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.**