

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042974

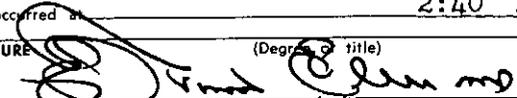
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5792

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 29 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 13 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 3808 Indiana 930 Olive St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Isiah Middle Thomas Last Thomas			4. DATE OF DEATH Month November Day 15 , Year 1962
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-29-04
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (last birthday) 57 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> IF UNDER 24 HR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (City and state or country) Barbara Co., Ala.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Sidney Thomas		13b. MOTHER'S MAIDEN NAME Mollie Lee	
14. NAME OF HUSBAND OR WIFE Mary Thomas		17. INFORMANT Address Mary Thomas 930 Olive 3808 Indiana	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Polycystic renal disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION 11-6-62 to 11-15-62 and last saw her/him alive on 11-15-62
21. I attended the deceased from 11-6-62 to 11-15-62 and last saw her/him alive on 11-15-62 . Death occurred at 2:40 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE 		22b. ADDRESS 2400 Cherry	
22c. DATE SIGNED 11-16-62		22d. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	
22e. LOCATION (City, town, or county) Kansas City, Mo.		22f. STATE Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11-24-62	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	23d. LOCATION (City, town, or county) Kansas City, Mo.
24. FUNERAL DIRECTOR Watkins Bros. Funeral Home		25. DATE RECD. BY LOCAL REG. 11-16-62	26. REGISTRAR'S SIGNATURE 

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF
2d	3808 Indiana	930 Olive
17	3808 Indiana	930 Olive
16	424-03-8893	Unknown

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION
Frank Ellis

USE BLACK INK OR TYPEWRITER RIBBON

VS 300
Rev. 4/59

1
23178

3

4 **2**

5 **1**

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7 **1**

8 **2**

9757.1

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11-
1257-0

13.

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bruce R. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Benton

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.