

FILED JAN 27 1947
Registration District No. 799

State File No.

Primary Registration District No. 1002

Registrar's No.

194

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: St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community 1 Day years, months or days)

3. (a) PRINT FULL NAME Sammie Ray Unloes

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex M. I 5. Color or race Wh. 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 1-13-1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 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 _____

MOTHER FATHER

12. Name Billie Unloes 0

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

14. Maiden name Therese Pinkston

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

16. (a) Informant Mrs. Billie Unloes

(b) Address 2519 Troost

17. (a) Burial (b) Date thereof 1-17-47
(Burial, cremation, removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton, Mo

18. (a) Signature of funeral director Mrs. C. Foster

(b) Address H.C. No

19. (a) 1-15-47 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 46
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2519 Troost
(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 14th
year 1947 hour 02 minute 9 M.

21. I hereby certify that I attended the deceased from 1-13-47 to 1-14-47 1947
that I last saw him alive on 1-14-47 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Sub Acute Hemorrhage Duration 34 hrs

Due to teuterial tear 34 hr.

Due to Left Occiput Posterior delivery - premature twin

Other conditions Forceps delivery.

Major findings: Of operations 1600
Of autopsy same

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 Les A. O'Brien (M. D. or other) M.D.
Address 1002 aryle K.C. Mo Date signed 1-15-47

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

Dr. Leo. P. Brown
Argyle Bldg. - 2-5 pm
#65537

1005

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 Dean Owens

Licensed Embalmer No. 4280
918 Brooklyn
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.