

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **13311**
1292
Registrar's No. _____

Registration District No. 299

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:
K.C. General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-31-41
3 Yrs. 10 Mos. (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Grace Tilford

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

4. Sex FEM 5. Color or race W 6. (a) Single, widowed, married; divorced Married
6. (b) Name of husband or wife George H. Tilford 6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased October 20, 1905
(Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days 11 If less than one day hr. _____ min. _____

9. Birthplace Missouri (City, town, or county) (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Wm. H. Miller
13. Birthplace Germany (City, town, or county) (State or foreign country) 4
14. Maiden name Floira L. Miller
15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant George H. Tilford
(b) Address 2001 Indep. Blvd.

17. (a) Burial (b) Date thereof 4-1-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheatland Mo
18. (a) Signature of funeral director Wheatland Mo
(b) Address Wheatland Mo
19. (a) Apr 1 1941 (b) W. M. Grove
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2001 Independence Blvd 8
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31st
year 1941 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from 3-31-41 19____ to 3-31-41 19____
that I last saw her alive on 3-31-41 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
Due to 13 B
Due to 12 B
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy None

Duration _____
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? _____

(Specify type of place) _____
While at work? _____ (c) Means of injury 0
23. Signature Dr. R. R. Shores (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

8
3
8

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..... *E. M. Plank*

Licensed Embalmer No. *1848*

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.