

FILED MAY 25 1944  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 2106

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: 3242 NORLEDGE  
McMAHON CONVALESCENT HOME  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 MONTHS  
(Specify whether  
In this community 24 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3242 NORLEDGE AVENUE  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. GRACE ESTELLE TRILLOW

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife MR. WILLIAM TRILLOW 6. (c) Age of husband or wife if alive 28 years  
7. Birth date of deceased NOVEMBER 28 1879  
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 15 If less than one day hr. min.

9. Birthplace ST. PAUL MINNESOTA  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name UNKNOWN OSTROM  
13. Birthplace BORDEAUX FRANCE  
(City, town, or county) (State or foreign country)  
14. Maiden name UNKNOWN  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. J. H. SMITH  
(b) Address 3035 EAST 59TH STREET

17. (a) CREMATION (b) Date thereof MAY-15-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEW COMERS SONS

18. (a) Signature of funeral director W. H. Newcomer's Sons  
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 5-15-44 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 12<sup>TH</sup>  
year 1944 hour 4 minute 00 P. M.  
21. I hereby certify that I attended the deceased from Feb 1  
1944 to May 12 1944  
that I last saw her alive on May 12 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic rheumatism, later arthritis  
Duration About 17 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_ 590  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 C. Blinn Recter (M.D. or other) D.O.  
Address 7204 Prospect Date signed 5-13-44

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

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**