

FILED APR 2 1946

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1322

1. PLACE OF DEATH:

(a) County Hepson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 53 min
(Specify whether years, months or days) 53 minutes

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48
(c) City or town Kansas City, Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 7932 Troost
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME June Virginia Stringer

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb - 28 1946
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 53 min.

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

10. Usual occupation infant

11. Industry or business _____

MOTHER, FATHER { 12. Name Ronald McDonald Stringer
13. Birthplace Carry N. Dak.
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Ruth Kirkpatrick
15. Birthplace Columbia Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Margaret Stringer
(b) Address 7932 Troost K.C. Mo.

17. (a) Exemation (Burial, cremation, or removal) (b) Date thereof 3-1-46
(Month) (Day) (Year)

(c) Place: burial or cremation Research Hosp

18. (a) Signature of funeral director Research Hosp

(b) Address H. C. Mo.

19. (a) 3-18-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
year 1946 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from 2-28, 1946, to 2-28, 1946
that I last saw h.e.r. alive on 2-28, 1946
and that death occurred on the date and hour stated above.
Immediate cause of death Profound Relational Typhoid fever with Abscess

Due to ?
Due to ?

Other conditions (Include pregnancy within 3 months of death) 1105

Major findings: Of operations _____

Of autopsy Abscess

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? PH Nurse (Specify type of place) (e) Means of injury _____

23. Signature R.N. Decker (Name of other) _____

Address North KC, Mo. Date signed 3/9/46

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

8 1/2

0000

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.