

S. No. 2
M-2-43
7. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30325
State File No. _____
Registrar's No. 3968

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas cy Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: KCTB Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 yr - 2 mo - 13 da
In this community 20 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas cy
(If outside city or town limits, write "RURAL")
(d) Street No. 2034 Madison
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Lara, Viola

3. (b) If veteran,

name war None

3. (c) Social Security

No. None

4. Sex

F

5. Color or race W

6. (a) Single, widowed, married, divorced SO

6. (b) Name of husband or wife

6. (c) Age of husband or wife

7. Birth date of deceased

Jan 18 1925
(Month) (Day) (Year)

all years
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

20

9

30

ht. min.

9. Birthplace

Kansas cy Mo
(City, town, or county) (State or foreign country)

(State or foreign country)

10. Usual occupation

Factory worker

11. Industry or business

MOTHER FATHER

12. Name Lara, Jean

13. Birthplace Mexico
(City, town, or county) (Country)

(Country)

14. Maiden name Frances Lopez

15. Birthplace Mexico
(City, town, or county) (Country)

(Country)

16. (a) Informant

KCTB Hospital

(b) Address

KC Mo

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

9-21-46
(Month) (Day) (Year)

(c) Place; burial or cremation

St. Marys

18. (a) Signature of funeral director

Weiler Funeral Home

(b) Address

K.C. Mo.

19. (a) 9-18-46

(Date received local registrar)

(b) Geraldine Holme
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 17 year 1946 hour 7 minute 25 AM/PM

21. I hereby certify that I attended the deceased from July 5 to Sept 17, 1946 that I last saw her alive on 9-17-46 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 1 1/2 yrs

Due to _____
Due to _____

Other conditions Tuberculous Enteritis 6 Mo
(Include pregnancy within 3 months of death)

Major findings: 13th
Of operations _____

Of autopsy Same
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 A. C. Hoffman (M. D. or other) MD
Address Kansas cy Mo Date signed 9-18-46

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

Blaine E. Walker

Licensed Embalmer No. *4075*

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.