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5-17-39  
P1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1291  
Registrar's No. 1

FILED JAN 17 1947  
Registration District No. 177

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kaw Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home 619 E. 8th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 2  
(If outside city or town limits, write "RURAL") 3

(d) Street No. 619 East 8th St 3  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mrs Grace L. Rast

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race Wh.

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

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 24 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

66 8 7 hr. \_\_\_\_\_ min.

9. Birthplace Sedalia Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

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

MOTHER FATHER { 12. Name James T. Thornberry

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

14. Maiden name Margaret E. Lester

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

16. (a) Informant L. J. Rast

(b) Address 814 Troost

17. (a) Removal (b) Date thereof Jan. 2 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedalia Mo

18. (a) Signature of funeral director Wornall Funeral Home

(b) Address 7406 Wornall

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan - day 1  
year 1947 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from Sept. 1  
1946, to Jan 1 1947  
that I last saw her alive on Dec 30 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure

Due to malignancy - metastases to liver & lungs.

Due to primary site unknown.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations UNK

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_ (e) Means of injury 2

23. Signature Warren M. Jones (M. D. or other) Do

Address 3401 E. 71 St. Date signed 1-1-47

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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.

*Howard G. Pol.*

Licensed Embalmer No.

*2748*

P. O. Address

*H. C. Md.*

**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.**