

S. No. 2
-12-45
5-17-39
P 1 X47070

FILED APR 8 1947
Registration District No. 177

Primary Registration District No. 1002

Registrar's No. 1384

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether _____)

In this community 40 yrs
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. 1010 Wyandotte
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Albia Farr

3. (b) If veteran, name war no -

3. (c) Social Security No. 3702-14-1660A

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
year 1947 hour 9 minute 15 P. M.

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Grace Farr

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

7. Birth date of deceased Oct-29-1867
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 19, 1947, to March 24, 1947, that I last saw him alive on March 24, 1947, and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>4</u>	<u>25</u>	by _____ min.

Immediate cause of death Meningitis type unknown

non epidemic

Due to _____

Due to _____

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

10. Usual occupation Retired News Butcher

11. Industry or business Missouri Pacific RR.

Other conditions (include pregnancy within 3 months of death) 8/0

Major findings: Of operations _____

Of autopsy See above

MOTHER FATHER

12. Name Ralph Farr

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

14. Maiden name Hannah Jane Stevens

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

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? _____

16. (a) Informant Walter Jones

(b) Address 3602 Benton Blvd

17. (a) Burial (b) Date thereof Mar. 26-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenhauer

18. (a) Signature of funeral director Wm C R Foster

(b) Address 915 Broadway

19. (a) 3-25-47 (Date received local registrar)

Alfredine Holman (Registrar's signature)

23. Signature Wm C R Foster (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 3-25-47

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

D. Laman

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 *Dean Owens*
Licensed Embalmer No. *4280*
P. O. Address *918 Brooks*
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.