

FILED MAY 20 1947

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2056

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

**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: NORTHEAST RESTORIUM  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 month  
(Specify whether)  
 In this community 20 yrs.  
years, months or days

**3. (a) PRINT FULL NAME** ADELAIDE L. FOLAND  
 3. (b) If veteran, name war NO  
 3. (c) Social Security No. NO

4. Sex Female / 5. Color or race White  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife William R.  
 6. (c) Age of husband or wife if alive 1866 years  
 7. Birth date of deceased June 20  
(Month) (Day) (Year)

**8. AGE:** Years 80 Months 10 Days 18  
 If less than one day hr. min.

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

10. Usual occupation At Home

**MOTHER FATHER**  
 11. Industry or business \_\_\_\_\_  
 12. Name George Byrd  
 13. Birthplace Indiana  
(City, town, or county) (State or foreign country)  
 14. Maiden name Amelia Burns  
 15. Birthplace Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant Restorium Record  
 (b) Address K.C. Mo.

17. (a) Removal (b) Date thereof 5/9/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Coffeyville, Kansas

18. (a) Signature of funeral director Freeman Mortuary  
 (b) Address 104 West 42nd St. K.C., Mo.

19. (a) 5-9-47 Geraldine Holme  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City, Missouri 3  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5715 Park Avenue 5  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No) 0  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 8th.  
 year 1947 hour 5 minute 15-P. M.

21. I hereby certify that I attended the deceased from April 29 1947 to May 8 1947  
 that I last saw her alive on May 8 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage with terminal pneumonia 1 mo. 1 wk.  
 Due to Bronchial arteriosclerosis hypertension

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

Major findings: Of operations 830  
 Of autopsy \_\_\_\_\_

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) (e) Means of injury  
 23. Signature Geraldine Holme (M. D. or other) Dr  
 Address 205 Date signed 5-9-47

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

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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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas City, 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.**