No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21208

FILED JUN 30 1947

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 2669

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: 3636 Drury
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 22 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 3636 Drury 8
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Sarah Tabron
3. (b) If veteran, name war: No
3. (c) Social Security No.: None

4. Sex: Female 2
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Walter Tabron
6. (c) Age of husband or wife if alive: 49 years
7. Birth date of deceased: March 13, 1900 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
47	3	6	hr. min.

9. Birthplace: Little Rock, Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: Ed Smith
13. Birthplace: Little Rock, Arkansas (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Minnie Mackson
15. Birthplace: Little Rock, Arkansas (City, town, or county) (State or foreign country)
16. (a) Informant: Walter Tabron
(b) Address: 3636 Drury 6-23-47
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Lincoln Cemetery
18. (a) Signature of funeral director: Watkins Bros.
(b) Address: 1729 Lydia
19. (a) 6-20-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: 6 day: 19 year: 1947 hour: 2 minute: 30 P.M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw him alive on ____, 19____; and that death occurred on the date and hour stated above.
Deputy Coroner

Immediate cause of death	Duration
Cardiac Failure	
Due to: Hypertensive Heart Disease	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 93 D	
Major findings: Of operations:	
Of autopsy: No — Permit	

PHYSICIAN
Underline the cause of 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: 0
23. Signature: H. Williams (M. D. ~~or other~~) H.C.
Address: 2634 Brooklyn Date signed: 6-20-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.