

FILED FEB 26 1940  
389

Registration District No. \_\_\_\_\_

Primary Registration District No. **1002**

Registrar's No. **143**

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: 3116 McGee  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 16 Yrs.  
In this community 16 Yrs.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Laura Belle Wholf  
3. (b) If veteran, name war XXX  
3. (c) Social Security No. no

4. Sex Fe. 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 Nov. 20 1861  
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 10 If less than one day hr. min.

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

10. Usual occupation Home

11. Industry or business None

MOTHER FATHER { 12. Name Ephrian Clark  
18. Birthplace Unknown Mo.  
14. Maiden name Julia Harris  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Al Wholf  
(b) Address 730 E. Meyer Blvd.

17. (a) Burial (b) Date thereof 1-13-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Orrick Mo.

18. (a) Signature of funeral director Eylar Funeral Home  
(b) Address 1800 Linwood K.C. Mo.

19. (a) 1-11-40 (b) M. M. Creve  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3116 McGee  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 11<sup>th</sup>  
year 1940 hour 7 minute 50 P. M.  
21. I hereby certify that I attended the deceased from JAN 1 1940  
to JAN 10 1940  
that I last saw h. EX alive on JAN 10 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza  
Due to Influenza  
Due to Chronic Catarrh Renal Disease  
Other conditions Chronic Catarrh Renal Disease  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 Jas. M. Walker (M. D. or other)  
Address 21424 Jasper Ave Date signed \_\_\_\_\_

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

130 to 5

11/10/03-36

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 Chas W. Tielkes  
Licensed Embalmer No. 2644  
P. O. Address 1800 Junewood

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, above space should be left blank.