

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

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: 136 N. White  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 25 Years / \_\_\_\_\_ (Specify whether  
years, months or days)

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. 136 N. White  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MADGE GRACE FARRINGTON

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Fe. 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Single 0

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

7. Birth date of deceased January 15, 1899  
(Month) (Day) (Year)

8. AGE: Years 42 Months 10 Days 24 If less than one day  
hr. \_\_\_\_\_ min.

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

10. Usual occupation None

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

12. Name Ira Penn Farrington

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

14. Maiden name Elizabeth Williams

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

16. (a) Informant Mrs. Ruth Campbell,  
(b) Address 136 N. White

17. (a) Burial (b) Date thereof 12-11-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C. H. BLACKMAN & SON, INC.  
(b) Address "2825 Indep. Blvd., K. G. Mo.,

19. (a) Dec 10 1941 (b) M M Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9  
year 1941 hour 11 minute 15 A. 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.

Immediate cause of death Coronary Occlusion Duration 4 day

Due to Chronic Valvular Heart Disease

Due to \_\_\_\_\_  
Other conditions 928  
(Include pregnancy within 3 months of death)

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature R. Williams (M. D. or other) M.D.  
Address 5400 St John Ave Date signed 12/10/41

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

86108

048  
3  
8

0

4 day

928

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

Dr. Williams  
No. 2659

**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 William L. Taylor  
Licensed Embalmer No. 4225  
P. O. Address Independence, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**