

FILED FEB 10 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 427

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

(d) Length of stay: In hospital or institution 1 Mo. & 5 days
(Specify whether years, months or days) 25 yrs

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. 1230 Cleveland
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Electa Farrington

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

4. Sex ♀ 5. Color or race wh 6. (a) Single, widowed, married, divorced, single

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

7. Birth date of deceased April 15 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 9 XVII hr. min.

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

10. Usual occupation Home work

11. Industry or business.....

12. Name Joyce Farrington

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

14. Maiden name Farrington

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

16. (a) Informant Miss Nellie Jarvis

(b) Address Sarnant St Pa

17. (a) Burial (b) Date thereof Jan 27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Mt Wash bury

18. (a) Signature of funeral director Rose T. Henderson

(b) Address 15 Jackson

19. (a) 1-27-43 (b) M. M. Brone
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26th
year 1943 hour 6 minute 30 A.M. P.M.

21. I hereby certify that I attended the deceased from 12-21-43, 19....., to 1-26-43, 19.....; that I last saw him en alive on 1-26-43, 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of right femur and right humerus, accidental fall in home

Due to.....
Due to..... 1862/16

Other conditions Hypostatic broncho-pneumonia
(Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy see above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) see above 123
(b) Date of occurrence 12-21-43
(c) Where did injury occur in home
(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 Dwight R. Thon (M. D. or other)
Address ed. Dir. K.C. General Hospital Date signed.....

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

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

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 *J. E. Henderson*.....

Licensed Embalmer No. *3657*.....

P. O. Address *15. 1st 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.