

FILED JUL 8 1945
Registration District No. 149

Primary Registration District No. 1002

State File No. _____
Registrar's No. 2795

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3mo 14 days
In this community 38 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank Villarreal

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Irene Villarreal 6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Oct 28 1898
(Month) (Day) (Year)

8. AGE: Years 44 Months 7 Days 21 If less than one day hr. min.

9. Birthplace San Antonio Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

12. Name Ramon Villarreal

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

14. Maiden name Francis Valley

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

16. (a) Informant Mrs Irene Villarreal

(b) Address 2307 Van Buren

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-43
(Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (e) Signature of funeral director Frank & Robert

(b) Address 25th & Greenwood
19. (a) 6-21-43 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

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. 2307 Van Buren
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19
year 1943 hour 3 minute 25 P. M.
I hereby certify that I attended the deceased from March 5 19 43 to June 19 19 43

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death brain abscess

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy see above

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) Means of injury _____

23. Signature Drury R. Thom (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

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 Harlyn Roe
Licensed Embalmer No. 2810
P. O. Address K. Q. 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.

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **2295**

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Frank Villarreal**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**

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

7. Birth date of deceased **Oct 25** (Month) (Day) (Year)

8. AGE: Years **44** Months **7** Days _____ (If less than one day, hr., min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** 19 **1943** year, _____ hour, _____ minute M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

Due to **Pyogenic organism type not known but not tuberculosis.**
Due to _____

Other conditions: (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

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

20655