

FILED NOV 1 1943 / 49
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4264

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: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Days (Specify whether)

In this community 29 Years (years, months or days)

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. 1715 East 29th Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country. ---

3. (a) PRINT FULL NAME Mrs. Emma Florence Guilfoyle

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th
year 1943 hour 9 minute 20 P. M.

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

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Mr. Joseph T. Guilfoyle 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased 10 - 17 - 1887
(Month) (Day) (Year)

Immediate cause of death Fracture of the femur

8. AGE: Years 61 Months 11 Days 19 If less than one day hr. min.

Due to Fracture of the femur

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

Due to Fracture of the femur

Other conditions Fracture of the femur
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Fracture of the femur

Of operations 1862

Of autopsy See above

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

11. Industry or business ---

MOTHER FATHER { 12. Name Jacob Stauffer

{ 13. Birthplace Unknown ⁹
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Unknown ⁹
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Joseph T. Guilfoyle

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident ¹²³

(b) Date of occurrence 9/27/43

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1943
(Month) (Day) (Year)

(c) Where did injury occur? 1715-2292 / 10th
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home Full yard

(c) Place: burial of preparation Mt. Moriah Cemetery

While at work? Yes (Specify type of place) (e) Means of injury ---

18. (a) Signature of funeral director D. H. Newcomer, Jr.

23. Signature [Signature] ³ (M.D. or other) ---

(b) Address 1401 Brush Creek Blvd.

Address [Signature] Date signed ---

19. (a) 10-7-43 (Date received local registrar) (b) J. E. Brown (Registrar's signature)

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.....

Licensed Embalmer No. 4043

P. O. Address N. C. 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.