No. 2
-2-43
17-39
X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1944

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 1777

Registrar's No. 426

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: In City Ambulance on way to General Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 9 Mos

2. USUAL RESIDENCE OF DEACESED:

(a) State: Mo. (b) County: Jackson

(c) City or town: Kansas City (If outside city or town limits, write "RURAL")

(d) Street No.: 5315 Lydia (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country: 1

3. (a) PRINT FULL NAME: David Leo Tarwater

3. (b) If veteran, name war: ---

3. (c) Social Security No.: ---

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: ---

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: April 10, 1943 (Month) (Day) (Year)

8. AGE: Years ____ Months: 9 Days: 13 If less than one day ____ hr. ____ min.

9. Birthplace: Kansas City, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Infant

11. Industry or business:

FATHER
12. Name: Daniel T. Tarwater, sr.
13. Birthplace: K.C. Mo. (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name: Delia Gavin
15. Birthplace: K.C. Mo. (City, town, or county) 0 (State or foreign country)

16. (a) Informant: Mrs Delia Tarwater
(b) Address: 5315 Lydia Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-25-44 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Mary's

18. (a) Signature of funeral director: Thos. E. Quirk Funeral
(b) Address: 4316 Troost Ave.

19. (a) 1-25-1944 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23rd year 1944 hour 10.41 A.M. M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h. Deputy Coroner ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Pulmonary Congestion aspiration pneumonia — Duration

Due to: Foreign Body in

Due to: Pharynx.

Strangulation (beads)

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations: 182-2

Of autopsy: See Above 1/8

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): Accident 13-3
(b) Date of occurrence: Jan. 23, 1944
(c) Where did injury occur: Kansas City Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? No (Specify type of place) (e) Means of injury: Strangulation
Home

23. Signature: A. E. Usher C. (M. D. or other) M.D.
Address: 23 McCoy Date signed 1/28/44

(Licensed Embalmer's Statement on Reverse Side)

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. 3775

P. O. Address.....

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.