

FILED SEP 7 1944

State File No.

3468

Registration District No. 149

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:
625 Kensington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
(Specify whether
In this community... 40 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Mo
(a) State... (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 625 Kensington
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country...

3. (a) PRINT FULL NAME Katherine McBride Driest

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

4. Sex Fem 5. Color or race White 6. (a) Single, widowed, divorced, Widowed
6. (b) Name of husband or wife Albert Driest 6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased 6 8 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 24
year 1944 hour 7:10 minute 19 M.
21. I hereby certify that I attended the deceased from 7-18, 1944 to 8-22, 1944

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death.
Due to Chronic myocardites
Chronic nephritis
Progny
Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations 15/15
Of autopsy

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) (c) Means of injury Q

23. Signed Dr. C. M. ... (M. D. or other) Dr. ...
Address ... Date signed 8/24/44

MOTHER FATHER

11. Industry or business
12. Name Teller
13. Birthplace No record a (City, town, or county) (State or foreign country)
14. Maiden name No record New York
15. Birthplace New York (City, town, or county) (State or foreign country)
16. (a) Informant Medde McBridee (son)
(b) Address 625 Kensington
17. (a) Burial (b) Date thereof 8/26/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cem.
18. (a) Signature of funeral director John P. Sheil
(b) Address Kansas City, Mo.
19. (a) 8-24-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

368

(Licensed Embalmer's Statement on Reverse Side)

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

48
3
8

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 *John P. Sheil* John P. Sheil

Licensed Embalmer No. 3625

P. O. Address *R E 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.