

U. S. No. 2
FORM-2-43
Rev. 5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8029

FILED MAR 19 1945

State File No. _____

Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 934

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K. C. MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months
In this community and 24 days (Specify whether years, months or days) same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City 48
(If outside city or town limits, write "RURAL") 3
(d) Street No. 4005 Forest
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
- If yes, name country _____

3. (a) PRINT FULL NAME Myra Tarr

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Oscar W. Tarr 6. (c) Age of husband or wife if alive dec. years
7. Birth date of deceased May 1 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 9 23 _____ hr. _____ min.

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

10. Usual occupation at home,

11. Industry or business X

MOTHER FATHER { 12. Name James Shaw
13. Birthplace Pennsylvania (City, town, or county) (State or foreign country)
14. Maiden name Sarah Ackers
15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant Harold Lamb,

(b) Address Ottawa, Kansas,

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 2-24-45
(Month) (Day) (Year)

(c) Place: burial or cremation Ottawa, Kansas,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 2-26-45 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 24 day year 1945 hour 9 minute 30 a.m.

21. I hereby certify that I attended the deceased from 12-1-44 19____, to 2-24-45 19____;

that I last saw her alive on 2-24-45 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident
Bronchial Pnaumonia

Due to _____

Due to _____

Other conditions 83a
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy as above

Duration

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) (e) Means of injury _____

23. Signature Clark W. Seely (M.D. or other) 2-24-45
Address K.C. General Hosp. #1 Date signed _____

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 E. M. Plouck

Licensed Embalmer No. 1848

P.O. Address T.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.