

FILED MAR 27 1946
Registration District No. **148**

Primary Registration District No. **1002**

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

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: **Conley Maternity Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **11 days**
(Specify whether years, months or days)
 In this community **11 days**

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. **412 S. Gladstone**
(If rural, give location)
 (e) Citizen of foreign country? **(Yes or No)**
 If yes, name country _____

3. (a) PRINT FULL NAME **Virginia Kay McGrath**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **January 19, 1946**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days **11** If less than one day _____ hr. _____ min.

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

10. Usual occupation **infant**

11. Industry or business _____

12. Name **Thomas Terrance McGrath**
 13. Birthplace **Glengean W. Virginia**
(City, town, or county) (State or foreign country)
 14. Maiden name **Ruth Virginia Viar**
 15. Birthplace **W. Virginia**
(City, town, or county) (State or foreign country)
 16. (a) Informant **Father**
 (b) Address **412 S. Gladstone, K.C. Mo.**

17. (a) **Preserved at Pathological Laboratory of Kansas City**
(Special examination, autopsy)
 (b) Date thereof **1-30-46**
(Month) (Day) (Year)
 (c) Place: burial or cremation **of Kansas City**

18. (a) Signature of funeral director **College of Osteopathy & Surgery as specimen**
 (b) Address _____
 19. (a) **3-13-46** (b) **Eraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **January** day **30**, year **1946** hour **10** minute **55 a. M.**

21. I hereby certify that I attended the deceased from **January 19, 1946** to **January 30, 1946** that I last saw him or her alive on **January 30, 1946** and that death occurred on the date and hour stated above.

Immediate cause of death **Alomerular nephritis with anuria** Duration **2 days**

Due to **Congenital bi-lateral polycystic kidneys** 11 days

Due to _____

Other conditions **157 hr**
(Include pregnancy, within 3 months of death)

Major findings: Of operations _____
 Of autopsy **Polycystic kidneys, Erythroblastosis fetalis**

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)
 Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____
(Specify type of place) (b) Means of injury
 23. Signature **Margaret Jones** (M. D. or other) **D.D.**
 Address **3 E 39th St. K.C. Mo.** Date signed **3-8-46**

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.....

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.