

BUREAU OF THE CENSUS  
**FILED APR 29 1946 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1790

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:  
7627 Oak Street /  
(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 4 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson, 48  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7627 Oak Street  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Mrs. Dorothy Beaumont Larson

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month April day 16  
year 1946 hour 9:55 minute P. M.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced, married

21. I hereby certify that I attended the deceased from 5 1946 to 4-15 1946

6. (b) Name of husband or wife Joseph H. Larson 6. (c) Age of husband or wife if alive unknown year

that I last saw her alive on 4/15 1946  
and that death occurred on the date and hour stated above.

7. Birth date of deceased March 3 1903  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>1</u>	<u>13</u>	hr. _____ min. _____

Due to Malignancy of breast.

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

Due to \_\_\_\_\_

10. Usual occupation housewife

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business X

Major findings: Of operations 50 PHYSICIAN \_\_\_\_\_

MOTHER FATHER } 12. Name unknown,

Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

13. Birthplace unknown,  
(City, town, or county) (State or foreign country)

14. Maiden name unknown,

15. Birthplace unknown,  
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph H. Larson

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

(b) Address 7627 Oak St., Kansas City, Mo.

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) removal (b) Date thereof 4-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Salt Lake City, Utah

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury no

19. (a) 4-17-46 (b) Doraldine Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature R. R. Coffey, M.D. (M. D. or other) no  
Address 1103 Bryan Date signed 4/17/46

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

*Griff Baldy*

Dr. R. R. Coffey

**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 *Robert H Reed*  
Licensed Embalmer No. *3745*  
P. O. Address *K.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.**