

FILED DEC 4 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1453

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:
4215 Windsor
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 62 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Jane H. Groff

3. (b) If veteran, name war no 3. (c) Social Security No. 496-24-5769A

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Henry C. Groff 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 18, 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>8</u>	<u>29</u>	hr. min.

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

10. Usual occupation Bookbinder

11. Industry or business

12. Name Robert W. Reid

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

14. Maiden name Annie Foster

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

16. (a) Informant H. V. Groff

(b) Address 1912 E. 58th

17. (a) Burial (b) Date thereof Nov. 19, 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Quirk & Tobin

(b) Address 20 W. Linwood

19. (a) 11-19-46 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 4215 Windsor 8
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17th
 year 1946 hour 5 minute 50 A.M.

21. I hereby certify that I attended the deceased from Nov 15
Nov 16th to Nov 16 1946
 that I last saw her alive on Nov 16
 and that death occurred on the date and hour stated above.

Immediate cause of death Influenza -
pneumonia - bronchial
in type with
 Due to Cardio-vascular
complications.
 Due to _____

Duration

Other conditions Arteriosclerosis and
(Include pregnancy within 3 months of death) nephritis

Major findings: Of operations _____

Of autopsy 13/a
 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? 2

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Elizabeth Marshall (M.D. or other) del.

Address 4212 Windsor Ave Date signed 11/19/46

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

MOTHER FATHER

Dr Marshall
Schubert Body

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.....

Maudie Adams

Licensed Embalmer No.....

4012

P. O. Address.....

20 W. Linwood

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.