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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8252

FILED MAR 21 1947

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

Registration District No. 59

Primary Registration District No. 4105-5234

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Cass  
(b) City or town Rural Peculiar Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 40 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo County Cass  
(b) City or town Rural Harrisonville  
(If outside city or town limits, write "RURAL")  
(c) Street No. \_\_\_\_\_  
(If rural, give location)  
(d) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME IDA BELL KAGARICE

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

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married 2 divorced 1 widowed

6. (b) Name of husband or wife J. H. Kagarice 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 15 1876  
(Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 17  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace Cass Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Home-maker

11. Industry or business \_\_\_\_\_

12. Name Wm a Lindsay

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

14. Maiden name Rachel Ann Brown

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

16. (a) Informant Nora Christensen  
(b) Address Harrisonville Mo.

17. (a) Rural (b) Date thereof Mar 6 - 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friend Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S  
(b) Address HARRISONVILLE, MO.  
19. (a) 3-8-1947 (b) Laura J. Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4  
year 1947 hour 11:53 minute A M.

21. I hereby certify that I attended the deceased from 2/2 19 47, to 3/2 19 47.  
that I last saw her alive on 3/2 19 47.  
and that death occurred on the date and hour stated above.

Immediate cause of death arterial hypertension, cardiac hypertrophy, mixed degeneration

Due to renal changes

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

Other conditions Hypertension  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 car

23. Signature Edward Zander (M. D. or other) Mo  
Address Plains Hill, Mo Date signed 16/47

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

MOTHER FATHER

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**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 *Ernest Kumburger*  
Licensed Embalmer No. *3368*  
P. O. Address *Harrisonville 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.**