

State File No. \_\_\_\_\_  
 Registrar's No. 1039

FILED SEP 8 1947  
 Registration District No. 42 Primary Registration District No. 1000

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

1. PLACE OF DEATH:  
 (a) County BUCHANAN  
 (b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
ST. JOSEPH'S HOSP. D  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 hrs 52 min  
(Specify whether)  
 In this community 7 yrs 6 mos 20 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County BUCHANAN  
 (c) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 205 Harvard  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Kathy Marie KARR  
 3. (b) If veteran, name war NO 3. (c) Social Security No. 140  
 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S, 0  
 6. (b) Name of husband or wife NO 6. (c) Age of husband or wife if alive 32 years  
 7. Birth date of deceased 8-30-17  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month AUG. day 30  
 year 1947 hour 4 minute 30 A. M.  
 21. I hereby certify that I attended the deceased from Aug 29 1947 to Aug 30 1947  
 that I last saw h. a alive on Aug 29 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Premature  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
0 0 6 hr. 52 min.  
 9. Birthplace ST. JOSEPH, MO  
(City, town, or county) (State or foreign country)  
 10. Usual occupation INFANT  
 11. Industry or business NO  
 12. Name IRA A. KARR  
 13. Birthplace HOLT, Co. Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name EVA CATHERINE MCGINE S  
 15. Birthplace FAIRFAX, MO.  
(City, town, or county) (State or foreign country)  
 16. (a) Informant IRA A. KARR  
 (b) Address 205 HARVARD, CITY  
 17. (a) BURIAL (b) Date thereof 8/31/47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation OREGON, MO.  
 18. (a) Signature of funeral director [Signature]  
 (b) Address 405 W. 1st St. City  
 19. (a) 9-2-47 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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?  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury 0  
 23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
 Address [Address] Date signed 9/30/47

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

**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.....

*Roland D. Clark*

Registered Apprentice No. *503*

working under my personal supervision.

Signed.....

*John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph, 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.**