

FILED NOV 24 1947
199

Registration District No. _____

Primary Registration District No. 1002

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks 5 days
(Specify whether years, months or days)

In this community 41 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte 999

(c) City or town Kansas City 14
(If outside city or town limits, write "RURAL")

(d) Street No. 1417 South 32d Street
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME Dorothy E. TOLER

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 married

6. (b) Name of husband or wife Robert F. Toler

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased May April 10, 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>40</u>	<u>56</u>	<u>27</u>
				hr. min.

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name Jacob W. Kendig

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

14. Maiden name Alta Lockett

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

16. (a) Informant Mr. Robt. F. Toler

(b) Address 1417 S. 32d St., K.C., Ks.

17. (a) Burial (b) Date thereof 11-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Melody-McGilley-Eylar

(b) Address Kansas City, Missouri

19. (a) 11-8-47 (b) M. R. Aldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day seven
year 1947 hour 4⁰⁰ minute P. M.

21. I hereby certify that I attended the deceased from October 11, 1947 to Nov. 7, 1947
that I last saw her alive on Nov. 7, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death generalized lymphosarcoma toxis

Due to diffuse lymphosarcoma

Due to primary site unknown

Other conditions (Include pregnancy within 3 months of death) 55 lb

Major findings: Of operations _____

Of autopsy all above

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? 0

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

23. Signature R. Paul Wright M.D. (M. D. or other) M.D.
Address 1329 Prof. Bldg. K.C. Mo. Date signed Nov. 7-47

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

18
3
8

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

Russell N. France

Licensed Embalmer No. *4255*

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.