

Registration District No. **149**

Primary Registration District No. **1002**

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

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: **K.C. General Hospital No. 1 0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In-hospital or institution **4 days** (Specify whether years, months or days)
 In this community **20 Years**

3. (a) PRINT FULL NAME **Kate Beard**
 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 **Widowed**
 6. (b) Name of husband or wife **Frank T. Beard**
 6. (c) Age of husband or wife if alive **years**
 7. Birth date of deceased **July 5, 1875**
(Month) (Day) (Year)

8. AGE: Years **73** Months **1** Days **8** If less than one day hr. min.

9. Birthplace **Jacksonville Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Dave Bird**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Marguarete Hall**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Beard**
(b) Address **Grandview, Mo.**

17. (c) Removal **Aug. 16, 48**
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)
(c) Place: burial or cremation **Shawnee Kans.**

18. (a) Signature of funeral director **Quirk & Tobin**
(b) Address **20 W. Linwood**

19. (a) 8-16-48 **(b) Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1436 Jefferson**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **13th**
 year **1948** hour **11** minute **20 P.** M.
21. I hereby certify that I attended the deceased from **8-9-48**, 19, to **8-13-48**, 19;
 that I last saw her alive on **8-13-48**, 19;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebra vascular hemorrhage**
 Due to
 Due to
 Other conditions **830**
(Include pregnancy within 3 months of death)

Major findings: **830**
 Of operations
 Of autopsy **None**
 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
23. Signature **Dir. K.C. Gen. Hospital** (M.D. print name)
 Address **8-11-48**
 Date signed

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 Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address Kansas City, 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.