

No. 2  
5-43  
5-17-39  
X 36671

FILED NOV 4 1948  
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:  
**105 West 39th Street**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **None**  
(Specify whether)  
In this community **27 years**  
(years, months or days)

3. (a) PRINT FULL NAME **Mrs. Sarah C. GRAHAM**

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 **Widow**  
6. (b) Name of husband or wife **Richard H. Graham** 6. (c) Age of husband or wife if alive **—** years  
7. Birth date of deceased **Dec. 10, 1866**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**81 10 5** hr. min.

9. Birthplace **St. Joseph, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER  
12. Name **John Connors**  
13. Birthplace **Unknown Ireland**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mollie Patton**  
15. Birthplace **Unknown Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Marie Weiss**

(b) Address **105 W. 39th St. K.C. Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-18-48**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

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

(b) Address **Kansas City, Mo.**

19. (a) **10-16-48** (Date received local registrar) (b) **Steraldine Holme** (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. **105 West 39th Street**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **15**  
year **1948** hour **9** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **Sept 14** to **Oct 15** 19**48**  
and that death occurred on the date and hour stated above.  
I last saw him alive on **Oct 14** 19**48**

Immediate cause of death **Coronary thrombosis**  
**arteriosclerosis**  
**severe**  
Due to **Coronary thrombosis**  
Due to **arteriosclerosis**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration  
**1 week**  
**1 MO**  
**year**

Major findings: Of operations **no**  
Of autopsy **no**

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) **no**  
23. Signature **John T. Skinner** (M. D. or other) **MD**  
Address **1103 Grand** Date signed **10/15/48**

**X. C. MO**

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

---

---

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**