S. No. 300
M—10-47
v. 5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 1 4 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 36545

Registrar's No. 4941

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~~: General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 1 mo. 11 days (Specify whether years, months or days)

In this community 30 YEARS

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.: 802 E. 11 St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: - - - - -

3. (a) PRINT FULL NAME: Miss Clara Grace Friel

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: DIVORCED

6. (b) Name of husband or wife: UNKNOWN

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

7. Birth date of deceased: JULY (Month) 9 (Day) ~~1893~~ 1896 (Year)

8. AGE: Years 52 ~~55~~ Months 4 Days ~~23~~ 22 If less than one day hr. min.

9. Birthplace: DODGE CITY (City, town, or county) KANSAS (State or foreign country)

10. Usual occupation: AT HOME

11. Industry or business: - - - -

MOTHER FATHER

12. Name: HUGH FRIEL

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

14. Maiden name: KATHERINE O'FARRELL

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

16. (a) Informant: MRS. MILDRED ESCHMEYER

(b) Address: 802 EAST 11TH STREET

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: DEC-4-1948 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~: MT. ST. MARY'S CEMETERY

18. (a) Signature of funeral director: D. W. Newcomb's Sons

(b) Address: 1401 BRUSH CREEK BLVD.

19. (a) 12-3-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 1 year 1948 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct. 20, 1948 to Dec. 1, 1948 that I last saw her alive on Dec. 1, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cirrhosis of liver with esophageal varices and ulceration-	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See 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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Wm. W. Hart (M.D. or other)

Address: Med. Dir. Gen'l Hosp. Date signed: 12-2-48

(Licensed Embalmer's Statement on Reverse Side)

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 Doyle L. Stone (Registered Apprentice No. 248), working under my personal supervision.

Signed Edward M. Storey

Licensed Embalmer No. 4452

P. O. Address K.C. 4 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.