

FILED NOV 16 1948

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 4375

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:
1849 Pennway Apt. 3A
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 13 years
years, months or days)

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. 1849 Pennway St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth Sadie Torres

3. (b) If veteran, name war None 3. (c) Social Security No. 499-10-2922

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Gabriel Torres 6. (c) Age of husband or wife if alive 36 years
 7. Birth date of deceased Feb. 12 1911
(Month) (Day) (Year)

8. AGE: Years 37 Months 8 Days 12 If less than one day hr. _____ min. 0

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

10. Usual occupation Seamstress

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9
 13. Birthplace Unknown 1
(City, town, or county) (State or foreign country)
 14. Maiden name Sarah Wagner
 15. Birthplace Unknown 4
(City, town, or county) (State or foreign country)

16. (a) Informant Gabriel Torres

(b) Address 1849 West Pennway Street

17. (a) Removal (b) Date thereof 10-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home (Specify type of rig) A. E. Upsher
(b) Address Springfield, Missouri (c) Manner of injury _____

19. (a) 10-27-48 (b) Geraldine Holman 23. Signature A. E. Upsher (M. P. No. 107348)
(Date received local registrar) (Registrar's signature) Address 2800 Main Dr. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct. day 24
 year 1948 hour 5:45 P.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebratory Failure Duration _____

Due to Alcoholism acute
 Due to _____

Other conditions MC
(Include pregnancy when a month of death)

Major findings: Deputy Coroner PHYSICIAN _____
 Of operations _____
 Of autopsy See Above
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? 6

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

NOV 13 1941

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 Blaine E. Weibert

Licensed Embalmer No. 4075

P. O. Address K.C. 8, 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.