

FILED SEP 7 1944

State File No. _____

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3419

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:
N. E. Restorium, 3240 Norledge 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 19 days
(Specify whether years, months or days)

In this community 19 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 67th. & Richmond Rural 0
(If rural, give location)

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

3. (a) PRINT FULL NAME Eulalia Martin

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

7. Birth date of deceased: October 17 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	10	0	_____ hr. _____ min.

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

10. Usual occupation Housewife

MOTHER FATHER {

12. Name John William Grafford

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Sara Galloway

15. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant John E. Martin

(b) Address 67th. & Richmond, K. C. Mo.

17. (a) Burial (b) Date thereof Aug 19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director George C. Cannon

(b) Address Independence, Mo

19. (a) 8-19-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from about July 15
1944 to Aug 2 1944
that I last saw her alive on Aug 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
Generalized carcinomatous
Primary in ovary

Due to _____

Due to 19 a

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 G. L. Humber M.D. (M.D. or other) _____
Address Plaza Med Bldg Date signed 8-18-44

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

1-3-48

See Attached
~~_____~~
~~_____~~

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 *Floyd C. Larson*

Licensed Embalmer No. *4199*

P. O. Address *Independence, 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.