

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1738
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 426
 (c) City Kansas City, Mo. (d) Street No. 1330 Bales Avenue K.C. Mo. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Johanna Fredicka Hale 400

(a) Residence, No. 1330 Bales St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 14, 1868
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 5 12
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. At Home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 25th, 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1938 to Jan 25, 1938
 I last saw her alive on Jan 25, 1938. Death is said to have occurred on the date stated above, at 9/45p.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy
53

Date of onset

Other contributory causes of importance:

Carcinoma of Eye
Weg. & Left frontal sinus
sinus. Meningeal cyst

Name of operation _____ Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____
 (Signed) Dr. Frank E. Day M. D.

(Address) 4316 E 9th K.C. Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

13. NAME N. Werning

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Mary Balkman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Mrs. Harry W. Smith, 1330 Bales,
 (ADDRESS) Kansas City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Clinton, Mo. DATE Jan. 28, 1938

19. FUNERAL DIRECTOR Mrs. C.L. Forster,
 (ADDRESS) Kansas City, Missouri.

20. FILED Jan 26, 1938 M. M. Crowe
 Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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RECEIVED

FEB 12 1938.

BUREAU OF VITAL STATISTICS
MO. STATE BOARD OF HEALTH

4316 E. 9th,
Phone, Be: 0162.
1.00 P.M.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

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.)