

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REC'D MAR 14 1938

5708  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township How Primary Registration District No. 1002 Registered No. 1272A  
 (c) City K.C. Mo (d) Street No. General Hospital 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 Gertrude Calloway 400  
 (a) Residence, No. 1715 Lydia 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 negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. Calloway  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 7-1894  
 7. AGE YEARS 42 MONTHS 8.6 DAYS 7 If LESS than 1 day, .....hrs. or .....min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, Domestic  
 9. Industry or business in which work was done, as saw mill, bank, etc. Domestic  
 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) 2-13-1938  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_  
 I last saw \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
Sanchar shock among  
Exsanguination  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England, Ark.  
 FATHER 13. NAME Jeff Saunders  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark  
 MOTHER 15. MAIDEN NAME Sophia Butler  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.  
 17. INFORMANT Sahrella Williams  
 (ADDRESS) 1406 E. 16th  
 18. BURIAL, CREMATION, OR REMOVAL K.C. Mo  
Blair Ridge Lawn DATE 2-16-38  
 19. FUNERAL DIRECTOR Flynn + Greenstreet  
 (ADDRESS) K.C. Mo  
 20. FILED 716 1938 M. M. Brown  
 Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis Injury Was there an autopsy Yes  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? Shunt Date of injury 2-12-38  
 Where did injury occur? 1717 Lydia  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. Home  
 Manner of injury Cut by knife  
 Nature of injury Exsanguination  
 24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) Russell W. Ben M. D.  
 (Address) K.C. Mo

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.

STATEMENT BY LICENSED EMBALMER

I, Flynn & Greenstreet, Inc., Licensed Embalmer No. 2211  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by Edward J. Evans  
No. 3836 L. E. \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
or by \_\_\_\_\_  
working under my personal supervision.

Signed J. M. G. Flynn  
Licensed Embalmer No. 2211

**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.)**