

REC'D AUG 8 1938

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

24326

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 339
(b) Township Ray Primary Registration District No. 1002
(c) City Ray, Mo. (d) Street No. General Hosp. #2 Registered No. 2831
(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

(a) Residence, No. 1821 E. 18th 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-6-1905
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 1 5 mail
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. mail
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oklahoma
13. NAME Don't know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
15. MAIDEN NAME Don't know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT (ADDRESS) Record Clerk
18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds Cem. DATE 7-13-38
19. FUNERAL DIRECTOR (NAME) (ADDRESS) West, Rappaport, Jas
20. FILED 7-13 1938 m 225 Central Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-11 1938
22. I HEREBY CERTIFY, That I attended deceased from 4-30 1938, to 7-11 1938
I last saw her alive on 7-11 1938 Death is said to have occurred on the date stated above, at 4:25 A.M.
The principal cause of death and related causes of importance were as follows:
Generalized Peritonitis secondary to Bilateral Sub-ovarian abscesses
Other contributory causes of importance: Chronic Appendicitis
Name of operation (Not operated)
What test confirmed diagnosis? Clinical Was there an autopsy? No
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? No
If so, specify _____
(Signed) J. Osburn M. D.
(Address) General Hosp #2

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U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF HEALTH SERVICES
NATIONAL BOARD OF EXAMINERS FOR EMBALMERS
1970

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,

C. H. West

, or by

Registered Apprentice No., working under my personal supervision.

Signed

C. H. West

Licensed Embalmer No.

2710

P. O. Address

1905 Vine

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

24326
Do not use this space.

PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township S.E.C. Primary Registration District No. 1002 Registered No. 2831
 (c) City S.E.C. (d) Street No. _____ 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.

PRINT FULL NAME

Florence Smith
 (a) Residence, No. _____ 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 7 4. COLOR OR RACE Cal 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 1 5

OCCUPATION
 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.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

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

FAMILY
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED July 13 1938 M. M. Browe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-11, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____.

I last saw him alive on _____, 19____. Death is said to have occurred on the day started above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Generalized Peritonitis
secondary to Bilateral Tubo-Ovarian abscess
through appendicitis
Gonorrhoea 35
 Date of onset _____

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) J. C. Turner, M. D.
 (Address) Gen Hosp., K.C.

SUPPLEMENT

