

DEAD SEP 13 1938

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

28060  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Kans. Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. 4509 E. 27 Registered No. 3371  
 (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

(a) Residence, No. 4509 E. 27 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 Fe 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Humphreys  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 5-1897  
 7. AGE YEARS 41 MONTHS 4 DAYS 18 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House.  
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 24 1938

22. I HEREBY CERTIFY, That I attended deceased from July 1937, to Aug 24 1938.  
 I last saw her alive on Aug 24 1938. Death is said to have occurred on the date stated above, at 9:30 a.m.  
 The principal cause of death and related causes of importance were as follows:

Myocardial Degeneration Date of onset July 1937  
 Other contributory causes of importance:  
Acute bronchitis Aug 1938  
and hypostatic pneumonia

Name of operation no Date of no  
 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  
 So, specify John F. Caldwell M. D.  
 (Signed) John F. Caldwell  
 (Address) 636 Deagle Bldg Kansas City, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway Co. Mo.  
 FATHER 13. NAME Geo. Strickland  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway Co. Mo.  
 MOTHER 15. MAIDEN NAME Jane Humphreys  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Callaway Co. Mo.  
 17. INFORMANT (NAME) (ADDRESS) John O. Humphreys  
4509 E. 27  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Woodlawn DATE Aug 26 1938  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Cyfar Funeral Home  
V. K. C. Mo  
 20. FILED Aug 26 1938 M. M. Brown  
 Local Registrar.

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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Ceryle Bealy No. 7170

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**