

REG'D SEP 13 1938

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

28089

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Jackson Primary Registration District No. 1002
(c) City Jackson City (d) Street No. 220 Gen Hosp Registered No. 3400
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (g) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 211 E 64 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Myers Myers
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 11 1877
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 60 10 14
8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Primary
9. Industry or business in which work was done, as saw mill, bank, etc. Primary
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) Mo

13. NAME Artie Fallis

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

15. MAIDEN NAME Viola Hoffman

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

17. INFORMANT Reverend Clegg
(ADDRESS) 220 Gen Hosp KCMo

18. BURIAL, CREMATION, OR REMOVAL PLACE Joplin Mo DATE Aug 29 38

19. FUNERAL DIRECTOR (NAME) Pasquino Bros
(ADDRESS) 220 Gen Hosp

20. FILED Aug. 28 38 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-25 1938

22. I HEREBY CERTIFY, That I attended deceased from 7-20 1938 to 8-25 1938

I last saw her alive on 8-25 1938 Death is said to have occurred on the date stated above, at 3:45 PM
The principal cause of death and related causes of importance were as follows:

Post operative Cholelithiasis
Chronic Cholelithiasis
Chronic Cholecystitis
Primary biliary fistula
Obesity
Toxic Myocarditis

Other contributory causes of importance:
Chronic Cholelithiasis
and Cholelithiasis

Name of operation Cholecystec Date of 7-25-38

What test confirmed diagnosis? Was there an autopsy? Yes

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) P. D. De Marna, M. D.

(Address) 501 K C Gen Hosp KCMo

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.