

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.

REC'D OCT 15 1938

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

31300  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Free Primary Registration District No. 1002 Registered No. 3597  
 (c) City Kansas City (d) Street No. 6626 Prospect 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 60 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Dr. Napoleon Bonaparte Winfrey 1511  
 (a) Residence, No. 6626 Prospect St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 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 Anna Jones Winfrey

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 19 1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, ..... hrs. or ..... min.
	<u>86</u>	<u>8</u>	<u>21</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc. Physician  
 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) Lone Jack Missouri

FATHER 13. NAME Caleb Winfrey  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Winetoh Salem N. C.

MOTHER 15. MAIDEN NAME Elizabeth Ann Shaw  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. C.

17. INFORMANT (ADDRESS) Mrs. J. B. Jackson 6632 Prospect

18. BURIAL, CREMATION, OR REMOVAL PLACE Cremation DATE Sept. 13 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. M. Newcomer 3054 Harrison

20. FILED Sept. 13 1938 M. M. Crowe Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 10 1938

22. I HEREBY CERTIFY, That I attended deceased from 12/1 1927, to 9/10 1938  
 I last saw him alive on 9/10 1938. Death is said to have occurred on the date stated above, at 6 P. M.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis  
Passive Pulmonary Congestion

Date of onset 11/27/37

Other contributory causes of importance:  
Acidosis  
Hypertension

Name of operation ..... Date of .....  
 What test confirmed diagnosis? Autopsy 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? .....  
 If so, specify .....  
 (Signed) W. H. Hill M. D.  
 (Address) 3054 Harrison  
714 2610

ATTACH TO GRAVES DEPARTMENT  
CERTIFICATE STATEMENT OF HEALTH  
RETURN TO THE STATE

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.

5034  
Hallman  
Va 3610

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

31300  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township K.C. Primary Registration District No. 1002  
 (c) City K.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.

Registered No. 3597-

2. PRINT FULL NAME

Nepalium B. Hinfrey M.D.  
 (a) Residence, No. 6476 Prospect St. \_\_\_\_\_  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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.  
86 8 21

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)

FATHER  
 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\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Aug 13/38 1938  
D. J. [Signature] Local Registrar.  
John. [Signature]

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 10 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 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:

Ch. Pericarditis  
Postive Pulmonary Congest.  
Stenosis  
 Other contributory causes of importance:  
Artemia - result of  
Chronic Nephritis

Date of onset

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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?

If so, specify John J. Hull M. D.  
 (Signed) \_\_\_\_\_ (Address) 3034 Harrison

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

