

REC'D OCT 15 1938

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

31503  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Raw Primary Registration District No. 1002 Registered No. 3800  
 (c) City K. C. Mo. (d) Street No. General Hospital #2 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

(a) Residence, No. 1320 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Unknown  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-11-1875  
 7. AGE YEARS 63 MONTHS 7 DAYS 15 If LESS than 1 day, ..... hrs. or ..... min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 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) Tenn.

FATHER 13. NAME Deceased - Unk

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

MOTHER 15. MAIDEN NAME Deceased - Unk

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT (ADDRESS) Record Clerk General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds Cem. DATE 9-30 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) West, Appleton & Sons City, Mo.

20. FILED 9/29 1938 M. W. Croove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-26 1938

22. I HEREBY CERTIFY, That I attended deceased from 8-25 1938, to 9-26 1938  
 I last saw him alive on 9-26 1938. Death is said to have occurred on the date stated above, at 3:15 a.m.  
 The principal cause of death and related causes of importance were as follows:

Carcinoma of Stomach Date of onset 4/6/38

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 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? 1  
 If so, specify \_\_\_\_\_  
 (Signed) J. O. Turner M. D.  
 (Address) General Hospital #2

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.

WHILE FILLING IN WITH CAREADING IMPRINTS THIS IS A PERMANENT RECORD

1 X14023

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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.....

*C. H. West,*

.....  
Licensed Embalmer No. *2710*

P. O. Address *K. E. M. O.*

**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.**