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.

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

34666
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 2 1 Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002 Registered No. 4002
(c) City Kansas City (d) Street No. 3032 E 20 Terrace 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 39 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Nancy Catherine Printz
(a) Residence, No. 3032 E 20 Terrace 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 White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Albert N. Printz
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 11, 1866
7. AGE YEARS 72 MONTHS 6 DAYS 1 If LESS than 1 day, ...hrs. or ....min.

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. At Home
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) Jefferson City Mo. 0

FATHER
13. NAME Allen Thomas 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calaway Co. Mo. 0

MOTHER
15. MAIDEN NAME Angeline Ryan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calaway Co Mo

17. INFORMANT (ADDRESS) Albert N. Printz 3032 E. 20 Terrace
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Morish DATE Oct 15 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. N. Newcomer's Son Brushcreek & Paseo.
20. FILED Oct 13, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 12, 1938
22. I HEREBY CERTIFY, That I attended deceased from July, 1934 to Oct 12, 1938
I last saw h..... alive on 10/12/38, 19..... Death is said to have occurred on the date stated above, at 11:40 P.m.
The principal cause of death and related causes of importance were as follows:
Thrombosis of Cerebral Artery. 59
Date of onset 10/1/38
Other contributory causes of importance Diabetes Mellitus
Name of operation No Date of
What test confirmed diagnosis? Physical 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) Joseph Mahler, M. D.
(Address) 925 Argyle Bldg

(Licensed Embalmer's Statement on Reverse Side)

Bell memorial Hosp

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 Nell Carr

Licensed Embalmer No. 3976

P. O. Address.....

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

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