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

DEC'D NOV 21 1938

34797
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 4133
(c) City Kansas City Mo — (d) Street No. St Vincent's Hospital 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 250 Mary Egan
(a) Residence, No. St. Vincent's Hospital 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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Infant
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 24-1938
7. AGE YEARS — MONTHS Mo DAYS 28 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
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) Kansas City Mo

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Helen Egan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chicago Ill

17. INFORMANT (ADDRESS) Sister Rose St Vincent's Hospital
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. St. Mary's DATE Oct 22 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner 204 West Linwood
20. FILED 10-24 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 22 1938
22. I HEREBY CERTIFY, That I attended deceased from 2/28/38 19.... to 10/22/38 19....
I last saw her alive on 10/21/38 19.... Death is said to have occurred on the date stated above, at 8 a.m.
The principal cause of death and related causes of importance were as follows:
Hydrocephalus following closure of Encephalomeningo Cele. 15 Ja — Date of onset 2/28/38.
Other contributory causes of importance:
Name of operation Encephalocoelectomy Date 2/10/38.
What test confirmed diagnosis? Was there an autopsy?
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 [illegible], M. D.
(Address) 925 Argyle Bldg

(Licensed Embalmer's Statement on Reverse Side)

Joseph D. Mercer
Argyle, Bldg.

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 compl with the above constitutes grounds for revocation of license.)

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