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 NOV 21 1938

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

34905
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kan
(c) City Kansas City
(d) Street No. K C Gen Hosp 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. 530
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 355
Primary Registration District No. 1002
Registered No. 4241

2. PRINT FULL NAME Sarah Bennett
(a) Residence, No. 609 E. 12th 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 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 Jno G. Bennett
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 3, 1871
7. AGE YEARS 67 MONTHS 6 DAYS 27 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home
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 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ks. 5

FATHER
13. NAME William Lee 5
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
15. MAIDEN NAME Margaret Maloney
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Record Clerk K C Gen Hosp KC Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt St Mary's Cem DATE 11/1, 1938
19. FUNERAL DIRECTOR (NAME) W F Mayberry (ADDRESS) Linwood & Olive
20. FILED Oct 31, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-30, 1938
22. I HEREBY CERTIFY, That I attended deceased from 10-21, 1938, to 10-30, 1938
I last saw he alive on 10-30, 1938 Death is said to have occurred on the date stated above, at 10:28 PM
The principal cause of death and related causes of importance were as follows:

	Date of onset
Auricular Fibrillation 95a	

Other contributory causes of importance:

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 .....
(Signed) P F De Maria, M. D.
(Address) Supt K C Gen Hosp KC Mo

(Licensed Embalmer's Statement on Reverse Side)

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.