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 14 1938

38093
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. 4327
(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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bessie Bater
(a) Residence, No. 1012 E 8th 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): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edmund H Bater
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6 1872
7. AGE: YEARS 66, MONTHS 0, DAYS 29. If LESS than 1 day, ...hrs. or ...min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Ohio

FATHER
13. NAME Isaac Runkle
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Edmund H Bater
(ADDRESS) 1012 E 8th
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mount Moriah 11/7 1938
19. FUNERAL DIRECTOR (NAME) Mrs. C. A. Foust
(ADDRESS) 918 Brooklyn
20. FILED Nov 6, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-4, 1938
22. I HEREBY CERTIFY, That I attended deceased from 10-31, 1938, to 11-4, 1938
I last saw her alive on 11-4, 1938 Death is said to have occurred on the date stated above, at 4:55 P.m.
The principal cause of death and related causes of importance were as follows: Date of onset
Cerebral hemorrhage 12 hr
Other contributory causes of importance:
Name of operation Date of
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?
If so, specify
(Signed) P. F. DeMarria 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.