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.

1938 DEC 14 1938

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

38408
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kan — Primary Registration District No. 1002 — Registered No. 4642
(c) City Kansas City — (d) Street No. KC 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 545 Jessie Scanland
(a) Residence, No. 3034 E. 32nd St. 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 Wm. N. Scanland
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-14-1865
7. AGE YEARS 73 MONTHS 5 DAYS 14 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) Glasgow Mo 0

FATHER
13. NAME John Barnes
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Md 0

MOTHER
15. MAIDEN NAME Amanda Haston
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saline Co Mo 0

17. INFORMANT (ADDRESS) Lester A. Scanland 3034 E. 32nd St.
18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Wash — DATE Nov. 30, 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. W. Newcomer's Sons Brush Creek & Paseo
20. FILED Nov 29, 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-28, 1938
22. I HEREBY CERTIFY, That I attended deceased from 11-27, 1938, to 11-28, 1938
I last saw her alive on 11-28, 1938. Death is said to have occurred on the date stated above, at 10:25 a m
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral sclerosis	
Cerebral Hemorrhage	
Encephalomalacia	
Other contributory causes of importance:	
Bronchopneumonia	

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? .....
If so, specify .....
(Signed) P. F. De Maria, M. D.
(Address) Supt KC Gen Hosp KC Mo

Licensed Embalmer's Statement on Reverse Side)

8 1/2

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 Neil Carr

Licensed Embalmer No. 3976

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.

7

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. 38408

Township — Primary Registration District No. 100V — Registered No. 464V

City Kansas City (No. Kansas City General Hosp St. ..... Ward)

2. FULL NAME Jessie Scanland

(a) Residence, No. 3034 E. 32nd St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
F	W	W

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, 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)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Nov. 29, 1938 M. M. Crowe
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 28, 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Sclerosis Arteris	
Cerebral Hemorrhage	
Encephalomalacia	8 2 W

Other contributory causes of importance:

Broncho pneumonia

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. De Maria Supt. T., M. D.

(Address) Kansas City General Hosp

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.