

REC'D JAN 1 1939

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

41698
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Jaw Primary Registration District No. 1002 Registered No. 4764
 (c) City J.C.M. (d) Street No. General Hospital #2 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

(a) Residence, No. 953 Bell 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-26-1896

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 6 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Domestic
 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) unknown (STATE OR COUNTRY) unknown

FATHER 13. NAME unknown

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

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT Record Clerk (ADDRESS) Gen Hosp.

18. BURIAL, CREMATION, OR REMOVAL PLACE Heads - mo DATE 12-13-38

19. FUNERAL DIRECTOR (NAME) H.B. Moore (ADDRESS) 1820 - 15th

20. FILED Dec 7 38 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-24 19 38

22. I HEREBY CERTIFY, That I attended deceased from 11-13, 1938 to 11-24, 1938

I last saw her alive on 11-24, 1938 Death is said to have occurred on the date stated above, at 6:16 P.M.

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

Encephalomalacia Date of onset 8/20

Other contributory causes of importance:

Pt. Ovarian Cyst
Pulmonary Congestion
and Edema
 Name of operation Edema
 What test confirmed diagnosis? ye Was there an autopsy? ye

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) J. O. Dunlop M. D.
 (Address) General Hospital #2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

I X14028

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,

J. B. Moore, or by

Registered Apprentice No., working under my personal supervision.

Signed J. B. Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E - 18th St

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

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