

REC'D JAN 13 1939

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

41772
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. 4838
 (c) City Kansas City (d) Street No. 2105 Montgall 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 14 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Jan Clemie Cade
 (a) Residence, No. 2105 Montgall 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 Fe 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 28, 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>71</u>	<u>10</u>	<u>5</u>	

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) (STATE OR COUNTRY) Cabin Creek Arkansas

FATHER
 13. NAME Joe Brown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cabin Creek ARK.

MOTHER
 15. MAIDEN NAME Jane Brown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cabin Creek ARK.

17. INFORMANT (ADDRESS) hula Wilson 2105 Montgall

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

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Adkins Bros. 2000 E. 12th

20. FILED Dec-12-1938 M. D. Gove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 3, 1938

22. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1938 to Dec 3, 1938
 I last saw him alive on Dec 1, 1938. Death is said to have occurred on the date stated above, at 8:15 A.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy Date of onset _____

Other contributory causes of importance:
Cerebral Sclerosis from diabetes mellitus

Name of operation _____ Date of _____
 What test confirmed diagnosis? albumin. 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? no
 If so, specify _____
 (Signed) W. S. Gove, M. D.
 (Address) 1836 Olive

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

I X14022

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.

57

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..... *Edw G Evans*

Licensed Embalmer No. *3836*

P. O. Address *1819 E 15th ST RY MO*

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.

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. PREVIOUS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact status of PREVIOUS is very important.

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
Township R.C.
City Clunie Castle

Registration District No. 399
Primary Registration District No. 1002

File No. 41272
Registered No. 4839
St. _____ Ward)

2. FULL NAME

(a) Residence, No. 2125 Montague Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS 71 MONTHS 10 DAYS 10 OF LESS than 1 day, hrs. or min.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED Dec 12 1938 by G. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec - 3 1938

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:

Cerebral Apoplexy -
Cerebral Sclerosis
(Arteriosclerosis)
Diabetes Mellitus

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) G. P. Turner _____, M. D. (Address) 1722 Vine

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

