

1939 JAN 1 3 1939

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

41818
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kow Primary Registration District No. 1002 Registered No. 4884
 (c) City Kansas City (d) Street No. 633 Brooklyn 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. da.

2. PRINT FULL NAME

(a) Residence, No. 240 Joseph Austin Purigley St. 633 Brooklyn (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 M 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 Bettie M Purigley
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
 7. AGE YEARS 75 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Photographer
 9. Industry or business in which work was done, as saw mill, bank, etc. Photographer
 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) Mo. O.
 FATHER 13. NAME Jack Purigley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 MOTHER 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 17. INFORMANT (ADDRESS) Bettie M Purigley
633 Brooklyn
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph DATE 12/16/38 1938
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. C. Foster
918 Brooklyn
 20. FILED Dec 14 1938 Dr. D. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-12-38 1938
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, 19____.
 I last seen on _____, 19____. Death is said to have occurred on the date stated above, at 10:00 a.m.
 The principal cause of death and related causes of importance were as follows:
Coronary sclerosis
Chronic myocardial infarction
Hypertrophy of the heart
 Other contributory causes of importance:
Acute pulmonary edema
 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) Dr. D. Brown M. D.
 (Address) Gen. Hosp; K. C. Mo.

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.

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 comply with the above constitutes grounds for revocation of license.)

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