

REC'D JAN 7 3 1939

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

41853

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 1 Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 4919  
 (c) City K. C. Mo 1 (d) Street No. St. Marys Hospital 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. 4908 Brookside Blvd 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Job Hollinger  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 10, 1891  
 7. AGE YEARS 47 MONTHS 3 DAYS 8 If LESS than 1 day, .....hrs. or .....min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) Omaha, Neb.

13. NAME Michael Loftus

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

15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT (ADDRESS) Miss. Betty Hollinger  
6112 Dorset

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. St. Marys DATE Dec 20, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John H. Wagner  
K. C. Mo

20. FILED Dec 19, 1938 M. M. Crowe  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/19, 1938

22. I HEREBY CERTIFY, That I attended deceased from about 12/5, 1938, to 12/19, 1938.

I last saw h. er alive on 12/19, 1938. Death is said to have occurred on the date stated above, at 8:15 p.m.

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

Dementia Praecox

Date of onset

Other contributory causes of importance: Intestinal Obstruction (atonic)

Name of operation none Date of

What test confirmed diagnosis? autopsy 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? no

If so, specify Saunders (Signed) W. M. D.

(Address) 221 Plaza Med Bldg  
K. C. Mo.

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.

WRITE IN INK WITH ENLARGING INSTRUMENTS IS A PERMANENT RECORD

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**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.**