REC'D JAN 13 1939

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

41934
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township Kaw
(c) City Kansas City, Mo.
(d) Street No. Menorah Hospital, K.C.Mo. 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.

Registration District No. 399
Primary Registration District No. 1002
Registered No. 5000

2. PRINT FULL NAME 540 Nell Finnell,
(a) Residence, No. No. Kansas City, Route #4. 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12, 1886

7. AGE: YEARS 52 | MONTHS 6 | DAYS 11 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
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) Louisanna

FATHER
13. NAME Unk St. Clair
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa.

MOTHER
15. MAIDEN NAME No Record
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT (ADDRESS) Mont Jones Finnell, 2105 Clay Str., No. K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Washington DATE Dec. 27th, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C.L.Forster 918 Brooklyn Avenue, K.C.Mo.

20. FILED Dec 24, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) December 23, 1938

22. I HEREBY CERTIFY, That I attended deceased from April 1932 to December 23, 1938
I last saw her alive on December 23, 1938 Death is said to have occurred on the date stated above, at 9 P.M.
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis with decompensation
Coronary sclerosis 93c

Date of onset

Other contributory causes of importance:
Bronchopneumonia 18
lower lobe

Name of operation None Date of
What test confirmed diagnosis? Phys. Exam 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) S. M. Shapiro, M. D.
(Address) 230 Argyle Bldg

(Licensed Embalmer's Statement on Reverse Side)

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.

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, ...

....., 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.