

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

41964
Do not use this space.

REC'D JAN 13 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City K. C. Mo Street No. 1405 Pacific St.
 (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.

Registered No. 5030

2. PRINT FULL NAME

(a) Residence, No. 1405 Pacific St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Truman Hlesha
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 15 - 1851
 7. AGE YEARS 87 MONTHS 11 DAYS 6 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, bakery, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-21-1938
 22. I HEREBY CERTIFY, That I attended deceased from Jan. 19-1938, to Dec. 21-1938.
 I last saw him alive on Dec. 21-1938. Death is said to have occurred on the date stated above, at 9:07 a.m.

The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy Date of onset
flow

Other contributory causes of importance:
Generalized Arteriosclerosis
 Name of operation none Date of
 What test confirmed diagnosis? none 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) H. B. Moore, M. D.
 Address Imp. 9th. 1405 St. 2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 FATHER 13. NAME Berry wise
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 MOTHER 15. MAIDEN NAME Mollie wise
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 17. INFORMANT Laralle Hlesha
 (ADDRESS) 1117 E-14 St
 18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE 12-27-38
 19. FUNERAL DIRECTOR H. B. Moore
 (ADDRESS) 1520 E-18 St.
 20. FILED 12-27-38 M. M. Crowe Local Registrar.

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.
 BOM-7-20-37 I I X12004

STATEMENT BY LICENSED EMBALMER

I, AB Moon, Licensed Embalmer No. 2410

hereby certify that the body recorded on the reverse side of this certificate was embalmed by AB Moon
L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed AB Moon
Licensed Embalmer No. 2410

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.)