

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

989
Do not use this space.

1. PLACE OF DEATH **REC'D FEB 20 1939** **3**
 (a) County **Jackson** Registration District No. _____
 (b) Township **Kaw** Primary Registration District No. _____
 (c) City **K.C.Mc.** (d) Street No. **4c1 East 36th.St** Registered No. _____ **2**
 (If death occurred in Hospital or Institution, write its name instead of street and number) 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.

2. PRINT FULL NAME **Martha Stanley Humphreys Maltby**
 (a) Residence, No. **5346 Troost** 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) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Arthur Norman Maltby**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 3, 1858**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 5 28

OCCUPATION 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 1, 1939**, 19__

22. I HEREBY CERTIFY, That I attended deceased from **Jan 1** 19**38** to **Jan 1** 19**39**
 I last saw **her** alive on **Jan 1** 19**39** Death is said to have occurred on the date stated above, at **4:50** Am.

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

Senile Dementia Jan 1/38 Date of onset **10/1/38**

Other contributory causes of importance:
Bradysp. Pneumonia 11/16/38
Atalaxia

Name of operation _____ Date of _____
 What test confirmed diagnosis **Clinical** 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) **M. J. White**, M. D.
 (Address) **114 St. Bldg. Kansas**

12. BIRTHPLACE (CITY OR TOWN) **Cole Co.** (STATE OR COUNTRY) **Missouri**

FATHER 13. NAME **David E. Humphreys**
 14. BIRTHPLACE (CITY OR TOWN) **West Virginia** (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Frances M. Goode**
 16. BIRTHPLACE (CITY OR TOWN) **Virginia** (STATE OR COUNTRY)

17. INFORMANT **Mrs Maurice M. Heltis** (ADDRESS) **5346 Troost**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Pleasant Hill** DATE **Jan. 3, 1939**

19. FUNERAL DIRECTOR (NAME) **J. F. O'Donnell Co.** (ADDRESS) **3256 Broadway**

20. FILED **Jan 1** 19**39** **Mr M. Craue** Local Registrar.

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.