

REC'D FEB 20 1939

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

1007

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. \_\_\_\_\_  
(b) Township Jean Primary Registration District No. \_\_\_\_\_  
(c) City Kansas City (d) Street No. 72 C Gen 120b 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.

Registered No. 20

## 2. PRINT FULL NAME

(a) Residence, No. 3425 Wayne 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 F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unk  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unk  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 60  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. unk  
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) St. Joseph Mo  
13. NAME (FATHER) (unk) Fanning  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk  
15. MAIDEN NAME unk  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk  
17. INFORMANT (ADDRESS) Gen Hosp Records  
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph DATE 1/3/39  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter M. Moore  
St. Joseph  
20. FILED Jan 3 1939 W. H. Brown  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2 1939  
22. I HEREBY CERTIFY, That I attended deceased from 12-31 1938 to 1-2 1939  
I last saw him alive on 1-2 1939 Death is said to have occurred on the date stated above, at 9:20 AM  
The principal cause of death and related causes of importance were as follows:  
Acute otitis media Date of onset \_\_\_\_\_  
with Streptococcus meningitis sga  
Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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) P. F. De Maria, M. D.  
(Address) 72 C Gen 120b Kansas City

(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.

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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

*Paul Anderson*

Licensed Embalmer No. 4056

P. O. Address St. Joseph - Mo

**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.**