

DEC'D FEB 20 1939

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

1152

Do not use this space.

Registered No. 165

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Jean Primary Registration District No. 1002
(c) City Jackson City (d) Street No. 5200 Central 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.

2. PRINT FULL NAME

(a) Residence, No. 5914 Jackson 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

MEDICAL CERTIFICATE OF DEATH

3. SEX m. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 19395A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate22. I HEREBY CERTIFY, That I attended deceased from 1-5 1939 to 1-13 19396. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14 1870I last saw him alive on 1-13 1939 Death is said7. AGE YEARS 68 MONTHS 7 DAYS 24 If LESS than 1 day, hrs. or min.to have occurred on the date stated above, at S. Swan
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
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.....

Melanocarcinoma Date of onsetof retina O.D. with metastasis 5312. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

Other contributory causes of importance:

13. NAME Samuel Stays14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo15. MAIDEN NAME Ank. Holloway16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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.

17. INFORMANT (ADDRESS) Dr. W. A. Clark18. BURIAL, CREMATION, OR REMOVAL PLACE Belton, Mo DATE 1-14 39

Manner of injury.....

Nature of injury.....

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dr. Newcomer's Sons

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) P. H. De Maria M. D.(Address) Sept 72 C Gen Hosp Jackson20. FILED Jan 14 1939 M. M. Browne Local Registrar.

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 conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.