

RECD FEB 20 1939

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

1175
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Jean Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 92 C. Ogden St Registered No. 188
 (e) Length of residence in city or town where death occurred yrs. mos. ds. 0 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Halstead Georgia
 (a) Residence, No. 1350 Prospect St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7. F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-14 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 1-9 1939 to 1-14 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 15-1882

I last saw him alive on 1-14 1939 Death is said to have occurred on the date stated above, at 7:20 PM

7. AGE YEARS 56 MONTHS 3 DAYS 29 If LESS than 1 day, hrs. or min.

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. Housework
 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

Cerebral Hemorrhage right side

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

Other contributory causes of importance:
Pneumonia

13. NAME Wm. Ealey

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? Yes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

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)

15. MAIDEN NAME No Record

Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

Manner of injury
 Nature of injury

17. INFORMANT (ADDRESS) Victor C. Halstead 2614 East 11th St

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) P. H. De Mania M. D.
 (Address) 32 C. Ogden St

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE 1-17-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Gault 918 Pershing K.C. Mo

20. FILED Jan 16 1939 M. H. Brown Local Registrar.

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

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