

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

REC'D FEB 20 1939

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

B. of H.

1184

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 197
 (c) City K.C.Mo. (d) Street No. 3341 Bales Avenue, K.C.Mo. 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 Russell Sage Townsend,

(a) Residence, No. 3341 Bales Avenue, K.C.Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 24th, 1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	40	-	21	

OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	<u>Clerk, Faeth</u>
	9. Industry or business in which work was done, as saw mill, bank, etc.	<u>Hdw. Co.,</u>
	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) Arkansas

FATHER 13. NAME Ada Townsend

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia

MOTHER 15. MAIDEN NAME Eliza Frazier

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois.

17. INFORMANT Elizabeth Martha Townsend
(ADDRESS) 3341 Bales Avenue, K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Arkadelphia, Ark DATE Jan. 16th, 39

19. FUNERAL DIRECTOR (NAME) Mrs. C.L. Forster
(ADDRESS) 918 Brooklyn, Ave., K.C.Mo.

20. FILED Jan 16 1939 39 M.M. Corone
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 15th, 1939

22. I HEREBY CERTIFY THAT I attended deceased from

I last saw him live on, 19 , to , 19 . Death is said to have occurred on the date stated above, at 7:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Scholaric Corditis
Acute Pulmonary Edema

Date of onset

Other contributory causes of importance:

Name of operation 99 Date of
 What test confirmed diagnosis? Culture Was there an autopsy?

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) Russell Sage Townsend, M. D.
 (Address)

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.