

REC'D FEB 20 1939

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

1197  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 30  
 (b) Township Jackson Primary Registration District No. 100  
 (c) City Kansas City (d) Street No. 72 C. Genl Hosp Registered No. 210  
 (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

(a) Residence, No. 105 S. Oakley 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) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clinton H. Lower  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-21 1908  
 7. AGE YEARS 30 MONTHS 5 DAYS 25 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W. W.  
 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) Kansas

FATHER 13. NAME Dennis Lavery

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

MOTHER 15. MAIDEN NAME Anna Ank

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

17. INFORMANT (ADDRESS) De W. Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE Jan 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. H. Blumhagen

20. FILED Jan. 17, 1939 M. M. Crowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-16 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 1-2 1939 to 1-16 1939  
 I last saw her alive on 1-16 1939 Death is said to have occurred on the date stated above, at 1:25 P.M.  
 The principal cause of death and related causes of importance were as follows:

Post operative  
Pneumonia 12/4/38  
 Other contributory causes of importance: Cholangitis; Arteriosclerosis of liver  
 Name of operation gynepharynx + uterine Date of 1-9-39  
 What test confirmed diagnosis? Yes 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.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? Yes  
 If so, specify \_\_\_\_\_ (Signed) P. H. De Mama M. D.  
 (Address) S. W. 72 C. Genl Hosp

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.**