

REC'D FEB 20 1939

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

1229  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Jean Primary Registration District No. 1002 Registered No. 242  
(c) City Stamansville (d) Street No. K C Gen Hosp 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. 6 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Ruth Arnold St.  (If nonresident, give city or town and State)  
Gladstone Hotel (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 1-6, 1939 to 1-9, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unp

I last saw her alive on 1-9, 1939 Death is said to have occurred on the date stated above, at 8:20 am

7. AGE YEARS 67 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ 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. 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 \_\_\_\_\_

Anteroseptic Date of onset 2  
Heart Disease 95

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

Other contributory causes of importance:

13. NAME Dora Reynolds

Interstitial Broncho  
Pneumonia

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

15. MAIDEN NAME unp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unp

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)

17. INFORMANT (ADDRESS) Record Clerk

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

18. BURIAL, CREMATION OR REMOVAL Forest Hill DATE 1-10-39

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

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John B. Papetich

24. Was disease or injury in any way related to occupation of deceased? 1  
If so, specify \_\_\_\_\_

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

(Signed) P. H. De Maria, M. D.  
(Address) Sept K C Gen Hosp Kcmo

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.**