

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

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

9483
Do not use this space.

1. PLACE OF DEATH

(a) County Clayton Registration District No. 399
 (b) Township Kan Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. K C Gen Hosp Registered No. 1089 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. 1310 E 9th 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 m 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 Doris Roberts
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 4 1875
 7. AGE YEARS 63 MONTHS 5 DAYS 5 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hotel Clerk
 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) Ohio

FATHER 13. NAME Scott Hoover

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Doris Knowlton

MOTHER 15. MAIDEN NAME Doris Knowlton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Doris Knowlton

17. INFORMANT (ADDRESS) Record Clerk
H. C. Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Williamburg Home DATE 5/11/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. F. Mayberry
H. S. Mo

20. FILED Mar 10 1939 M. M. Kramer
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-9 39

22. I HEREBY CERTIFY, That I attended deceased from 11-20 38 to 3-9 39
 I last saw him alive on 3-9 39. Death is said to have occurred on the date stated above, at 6:20 P.M.
 The principal cause of death and related causes of importance were as follows:

Ca of Bladder
Post operative shock

Other contributory causes of importance: SI

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? NO

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) P. J. De Maria M. D.
 (Address) Sup. K C Gen Hosp

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.