WHITE 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.

APR 17 1939

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

9545
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Co., Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002 Registered No. 1151
(c) City Kansas city (d) Street No. St. Lukes Hospital 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 Benjamin Walker Trelease
(a) Residence, No. 430 West 57th Street. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 4, 1922
7. AGE: YEARS 16 MONTHS 9 DAYS 8 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Student
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): California 1

FATHER
13. NAME: Richard M. Trelease 4
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): England 9

MOTHER
15. MAIDEN NAME: Ruth J. Walker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unk

17. INFORMANT (ADDRESS): Rev. Richard M. Trelease, 430 West 57th St. Hi-6537
18. BURIAL, CREMATION, OR REMOVAL
PLACE: Elmwood ~~SX~~ DATE: 3/15/39, 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Cremation Stine & McClure, 3235 Gillham Plaza
20. FILED: Mch 14, 1939 M. M. Brown, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 3/12/39, 19
22. I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 12, 1939
I last saw him alive on March 11, 1939. Death is said to have occurred on the date stated above, at 7:25 A.m.
The principal cause of death and related causes of importance were as follows:
Congenital bilateral hydronephrosis
Since birth. 15 Days
Date of onset
Congenital

Other contributory causes of importance:
Bilateral Pyonephrosis.

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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) [signature], M. D.
(Address) 1524 Professional

(Licensed Embalmer's Statement on Reverse Side)

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.