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.

REC'D APR 17 1939

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

9573
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 2 Registration District No. 399
(b) Township Mare 1 Primary Registration District No. 1002 Registered No. 1179
or
(c) City Kansas City (d) Street No. 1212 Harrison 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 333 Eli Meade Hutchison
(a) Residence, No. 1212 Harrison 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 M
4. COLOR OR RACE Mh
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nancy Jane Hutchison
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mch 31-1857
7. AGE YEARS 81 MONTHS 11 DAYS 15 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Slackman
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) Mo

FATHER
13. NAME Cap Samuel James Hutchison
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

MOTHER
15. MAIDEN NAME Caroline Matilda Fairchild
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT (ADDRESS) Nancy Jane Hutchison 1212 Harrison
18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn DATE Mar-18 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Forster 918 Brooklyn K.C. Mo
20. FILED Mch 17 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mch 16, 1939
22. I HEREBY CERTIFY, That I attended deceased from March 9, 1939, to March 16, 1939
I last saw him alive on March 16, 1939. Death is said to have occurred on the date stated above, at 6:30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	March 9 1939
10 8	
10 8	

Other contributory causes of importance:
Decompensating Heart

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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? no
If so, specify .....
(Signed) E. J. E. Evans, M. D.
(Address) 1411 Waldheim Bldg.

(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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.