

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

Do not use this space.

9650

1. PLACE OF DEATH

County Jackson  
Township Kaw  
City K. C. Mo. (No. \_\_\_\_\_)

Registration District No. 399  
Primary Registration District No. 1002  
St. Joseph's Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 1256

2. FULL NAME 536 Rita Andrews

(a) Residence, No. St. Anthony's Home St., \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 9, 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 7 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as silk mill, 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) Iola, Kansas

FATHER 13. NAME James Andrews

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

MOTHER 15. MAIDEN NAME Myrtle Walguthmuth

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chillicothe, Mo.

17. INFORMANT (ADDRESS) Sister Mary Joseph  
St. Anthony's Home

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's DATE Mar. 23, 1939

19. UNDERTAKER (ADDRESS) J. W. Wagner  
K. C. Mo.

20. FILED Mar 23 1939 M. M. Brown  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to March 22, 1939  
I last saw him alive on Mar 22, 1939. Death is said

to have occurred on the date stated above, at St. Joseph's Hospital.

The principal cause of death and related causes of importance were as follows:

Bronchial Pneumonia Date of onset Mar 17-39  
Secondary to Upper Respiratory  
Tract Infection  
Pneumonia was Bilateral 110

Other contributory causes of importance:  
Probably Influenza  
Pneumonia

Name of operation None 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? St. Joseph's Hospital  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None  
Nature of injury \_\_\_\_\_

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

(Signed) Joseph A. Conrad, M. D.  
(Address) 1308 Waldheim Bldg.

