

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

9703

Do not use this space.

REC'D APR 17 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kaw Primary Registration District No. 1107

(c) City Kansas City (d) Street No. St. Joseph Hospital. Registered No. 1309

(e) Length of residence in city or town where death occurred 53 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 4 yrs. mos. ds.

2. PRINT FULL NAME Mrs. Gertrude FLATER.

(a) Residence, No. 3117 Paseo Blvd. 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 Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John M. Flaters.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 23, 1864.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	74	7	2	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home.

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) West Point Iowa.

FATHER

13. NAME William Dingman

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

MOTHER

15. MAIDEN NAME Ama Bisher

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

17. INFORMANT Ruth L. Flater (Daughter) (ADDRESS) Houston Texas.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 3/27/39 1939

19. FUNERAL DIRECTOR (NAME) Melody McGilley. (ADDRESS) K. C. Mo.

20. FILED Mar 26 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 16, 1939, to March 25, 1939

I last saw him alive on March 24, 1939. Death is said to have occurred on the date stated above, at 2 P. M.

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

Hypertensive Myocarditis

Heart Block 3-1

Date of onset
?
?

Other contributory causes of importance:

Arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? EXG. Was there an autopsy? Yes

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) Jack W. Wray M. D.

(Address) 620 Apple Bldg. Kansas City, Mo.

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.

Eyes Blue
Hair Gray
Height 5' 3 1/2"
Weight 125
JH

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.