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

REG'D APR 17 1939

9707
Do not use this space.

Registered No. 1313

1. PLACE OF DEATH

(a) County Jackson — Registration District No. 399

(b) Township Kansas — Primary Registration District No. 1002

(c) City Kansas City — (d) Street No. 5604 Olive 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 Estella Catherine Hood

(a) Residence, No. 5604 Olive 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: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept. 7 1855

7. AGE: Years 84 Months 6 Days 18 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housewife

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: Samuel Jameson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

MOTHER

15. MAIDEN NAME: Sarah Palmer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Va.

17. INFORMANT (ADDRESS): Daughter - Mrs. Palmer 5604 Olive

18. BURIAL, CREMATION, OR REMOVAL

PLACE Creston Iowa DATE 3-27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Theisen Funeral

20. FILED Mar 26, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 3/17/39 to 3/25/39, 19..

I last saw her alive on 3/25/39, 19.. Death is said to have occurred on the date stated above, at 6:45 p.m.

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

	Date of onset
Myocarditis (Heart Failure)	
93 D1	

Other contributory causes of importance: Senility

Name of operation: None Date of: —

What test confirmed diagnosis? None. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No 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) Edward Heller M. D.

(Address) 1010 Professional 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 compl with the above constitutes grounds for revocation of license.)

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