

REC'D APR 17 1939

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

9763  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Ross Primary Registration District No. 1002  
(c) City Kansas City (d) Street No. Children's Mercy 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 320 Pinkey Stack

(a) Residence, No. 320 Pinkey Stack St.  Excelsior Springs Mo.  
(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>3-9-38</u>		
7. AGE YEARS <u>1</u>	MONTHS	DAYS <u>21</u>
If LESS than 1 day, ..... hrs. or ..... min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>None</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>-</u>	
	10. Date deceased last worked at this occupation (month and year) <u>-</u>	11. Total time (years) spent in this occupation <u>-</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Excelsior Springs Mo.</u>		
FATHER	13. NAME <u>Nin Stack</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Orrick Missouri</u>	
MOTHER	15. MAIDEN NAME <u>Faye Mc Bluee</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield Missouri</u>	
17. INFORMANT (ADDRESS) <u>Father Mr. Nin Stack Excelsior Springs Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Excelsior Spgs Mo.</u> DATE <u>April 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Herbert Hope Excelsior Springs Mo.</u>		
20. FILED <u>Mar 30 1939 M. M. Browe</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 30, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 30, 1939 to Mar 30, 1939  
I last saw h. em alive on Mar 30, 19..... Death is said to have occurred on the date stated above, at 2 A m.  
The principal cause of death and related causes of importance were as follows:  
Bilateral Bronchopneumonia  
grippe  
107a

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
What test confirmed diagnosis?..... 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?  
If so, specify W. S. Browe M. D.  
(Signed) W. S. Browe M. D.  
(Address) 5717 W. York St.

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.

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**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.**