

APR 17 1939

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

9776
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 395
 (b) Township Howe Primary Registration District No. 1007
 (c) City Heimo (d) Street No. Gen Hosp 11 @ 4282 St. Mo
 (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 607 Alice Lehn
 (a) Residence, No. 1005 Prospect St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Lehn
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec - 19 1879
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 2 28
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-17-39
 22. I HEREBY CERTIFY, That I attended deceased from 3-12-39, 1939, to 3-17-39, 1939.
 I last saw her alive on 3-17-39 Death is said to have occurred on the date stated above, at 12:30 pm.
 The principal cause of death and related causes of importance were as follows:
Pneumonia Date of onset 121
 Other contributory causes of importance:
Chronic vasular nephritis
 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 _____
 (Signed) P. H. De Maria, M. D.
 (Address) 5472 Cambridge

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas
 FATHER 13. NAME Chemus Dept
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Geny
 MOTHER 15. MAIDEN NAME Agnes Lemmy
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill
 17. INFORMANT (ADDRESS) Gen Hosp
 18. BY _____ (L. CREMATION; OR REMOVAL) Hand Hills Cent DATE 3-19-39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm B. Spelman
3736 Campbell St
 20. FILED 3731 1939 Dr. M. Brown
 Local Registrar.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

1 X14023

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.