

REC'D MAY 10 1939

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

13886

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 1640
 (c) City Kansas (d) Street No. 601 E 8th St 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

500
 (a) Residence, No. 601 E 8th St 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 Frank Dunaway
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEP 19 1890
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 6 28
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 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) Lehigh mo

FATHER 13. NAME Henry Werthman
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Do not know.
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know.

17. INFORMANT (ADDRESS) Frank Dunaway
601 E 8th St

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlawn DATE 4-20-19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Parantrio Bros
K.C. Mo.

20. FILED Apr 19 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/17/39 19

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____.

I saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ a.m.

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

Acute & chronic ulcerations of the left leg
Generalized bacterial septicemia

Other contributory causes of importance:

Multiple lung abscesses

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) Geo. H. Brown M. D.
 (Address) Greenlawn; K.C. Mo

1142

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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES
DALLAS, TEXAS

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. 1640
(c) City..... (d) Street No. 601 E 8th 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

Lydia Muraway
(a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 4/19/39 J. M. Grows Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

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

Acute & Chronic Ulceration of Left Leg
Generalized Tubercular Lesion
Date of onset 1939

Other contributory causes of importance:

Multiple lung abscess
Drug habit and site of injection became infected

Name of operation..... 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?..... (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)....., M. D.

(Address).....

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

