

LESD MAY 10 1939

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

13940
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Leaw Primary Registration District No. 1002
 (c) City K.P. (d) Street No. 3422 Tracy 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 John Renner
 (a) Residence, No. 3422 Tracy 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 M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 31 - 1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 2 22

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

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) Austria

FATHER 13. NAME Martin Renner

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

MOTHER 15. MAIDEN NAME Vronica

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

17. INFORMANT Mrs Anna Renner
 (ADDRESS) 3422 Tracy

18. BURIAL, CREMATION, OR REMOVAL PLACE Shannon Cem DATE April 25 1939

19. FUNERAL DIRECTOR (NAME) John D. Ganser
 (ADDRESS) 1415 Grand 15

20. FILED Apr 23 1939 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 22 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 4 - 39 to Apr 20 39, 1939.
 I last saw him alive on Apr 4, 1939. Death is said to have occurred on the date stated above, at 5:00 A.M.
 The principal cause of death and related causes of importance were as follows:
Poornuchyniaemia - Chronic
 Date of onset Apr 3 1939

Other contributory causes of importance: 131

Name of operation _____ Date of _____
 What test confirmed diagnosis? Bob Was there an autopsy? no

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? yes
 If so, specify _____
 (Signed) J. J. Shannon M. D.
 (Address) 116 E. Avenue 1500

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.

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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.

Handwritten notes and markings on the right side of the page, including a large 'A' and other illegible characters.