

REC'D MAY 10 1939

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

14030

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Law Primary Registration District No. 1002
 (c) City N E MO (d) Street No. 19 E Sen St.
 (e) Length of residence in city or town where death occurred 150 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1784

2. PRINT FULL NAME

(a) Residence, No. 3709-E-9 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 (with the word) Widow
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-26-1875
 7. AGE YEARS 93 MONTHS 9 DAYS 0 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 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) Ohio13. NAME Ann Emery14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown15. MAIDEN NAME Amelia C. Howell16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown17. INFORMANT (ADDRESS) Recd. Clerk N E Sen Hosp18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE April 29th, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Forster 918 Brooklyn Avenue, K.C.Mo.20. FILED Apr 28 39 m. m. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-26-3922. I HEREBY CERTIFY, That I attended deceased from 3-23-39, 1939, to 4-26-39, 1939I first saw her alive on 4-26-39, 1939 Death is said to have occurred on the date stated above, at 1157 hrs.

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

Fracture of Femur
accidental fall
in home
18 hrs
15

Other contributory causes of importance:

General Debility
 Date of onset

Name of operation _____ Date of _____

Was test confirmed diagnosis? _____ Was there an autopsy? MP

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

Accident, suicide, or homicide? Accident Date of injury 3-23, 1939Where did injury occur Accidental fall at home (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 Fracture of femur

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. P. De Maseo M. D.(Address) Sept N E Sen Hosp

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.

Corrected by affidavit June 29-1939 L. Wood

See affidavit #197 in misc file 1139

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.