

REC'D MAY 10 1939

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

14069

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
(b) Township Kaw Primary Registration District No. 1002 Registered No. 1823
(c) City Kansas City (d) Street No. 423 E. Meyer Blvd. St.
35 (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 Mrs. Captolia Speas

(a) Residence, No. 423 E. Meyer Blvd. 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John H. Speas</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>August 14, 1874</u>				
7. AGE	YEARS <u>64</u>	MONTHS <u>8</u>	DAYS <u>15</u>	IF LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>At home</u>			
	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) <u>Missouri</u>				
FATHER	13. NAME <u>Clinton Walker</u>			
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Indiana</u>				
MOTHER	15. MAIDEN NAME <u>Sarah Frances Cofer</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
17. INFORMANT (ADDRESS) <u>Stanley M. Speas</u> <u>423 E. Meyer Blvd.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Forest Hill</u> DATE <u>May 1, 1939</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Freeman Mortuary</u> <u>104 W. 42nd St., K. C., Mo.</u>				
20. FILED <u>May 1, 1939</u> <u>M. M. Crowe</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/29 1939
22. I HEREBY CERTIFY, That I attended deceased from April 7 1939 to Sept 1938
I last saw her alive on Sept 1938. Death is said to have occurred on the date stated above, at 10 A.m.
The principal cause of death and related causes of importance were as follows:

Date of onset
Cerebral Hemorrhage 4/29/39
82.05
Other contributory causes of importance:
arteriosclerosis + hypertension 1938

Name of operation none Date of entry clinical
What test confirmed diagnosis? autopsy 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? no
If so, specify
(Signed) Edwin Villalobos M. D.
(Address) Plaza Med. Bldg. 1-15 C. mo

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.