REC'D JUN 8 1939

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

17720
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. 2122
(c) City K C Mo
(d) Street No. K C Gen Hospt 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 25 yrs. mos. ds.
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 426 Ethel Flesher
(a) Residence, No. 3100 E. 11 St. St.
(Usual place of abode, if no street address, write county or city)
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 7 1884

7. AGE YEARS 55 MONTHS 1 DAYS 17 If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Record clerk K C Gen Hospt

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Forest Hill DATE 5-22- 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carroll-Davidson 3024 Troost, K. C. Mo.

20. FILED May 21, 1939 M. M[illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-19-39 19

22. I HEREBY CERTIFY, That I attended deceased from 4-22-39, 19..., to 5-19-39, 19...
I last saw her alive on 5-19-39, 19... Death is said to have occurred on the date stated above, at 11 30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hodgkins Sarwma	
72 B	

Other contributory causes of importance:

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) Supt K C Gen Hospt

(Li[illegible]mbalmer's Statement on Reverse Side)

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.

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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.