REC'D JUN 8 1939

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

17855
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township — Primary Registration District No. 1002 — Registered No. 66
(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 2 yrs. 8 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Inf. Best
(a) Residence, No. 622 E-15 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 WORD) Stillbirth

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-3-39

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

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stillbirth
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) K C Mo

FATHER
13. NAME Melvin Best
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

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

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

18. BURIAL, CREMATION, OR REMOVAL Fred C Cemt DATE 5-4-39

19. FUNERAL DIRECTOR (NAME) Peter B Kaufman
(ADDRESS) 236 Campbell St

20. FILED May 4, 1939 M. M. Browne
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-3-39, 19

22. I HEREBY CERTIFY, That I attended deceased from 5-3-39, 19..., to 5-3-39, 19... I last saw h... alive on 5-3-39, 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:

	Date of onset
Poorly developed	
and Nourished Premature	
Twins	

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. L. DeMarco, M. D.
(Address) K C Gen Hospital

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X14028

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.