

WED JUL 10 1939

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

21160  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson <sup>2</sup> Registration District No. 399  
 (b) Township Kaw <sup>1</sup> Primary Registration District No. 1009 Registered No. 2428  
 (c) or City K. C. Mo. (d) Street No. 4042 College 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 Mrs. Anna Augusta Hale  
 (a) Residence, No. 4042 College 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 (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 6, 1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>75</u>	<u>10</u>	<u>6</u>	

OCCUPATION

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

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) Indiana /

FATHER

13. NAME Thomas Davis, /

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana /

MOTHER

15. MAIDEN NAME Evaline Lett

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

17. INFORMANT (ADDRESS) Mrs. Myrtle Mitchell  
4042 College

18. BURIAL, CREMATION, OR REMOVAL PLACE Floral Hills DATE June 14, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner  
Kansas City, Mo.

20. FILED June 14, 1939 M. M. Crowe, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 12, 1939

22. I HEREBY CERTIFY that I attended deceased from Aug 1, 1937, to June 12, 1939  
 I last saw him alive on June 12, 1939 Death is said to have occurred on the date stated above, at 1 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of stomach Date of onset 1937  
46

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? None (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) Robert C. Swisher M. D.  
 (Address) 838 Argyle Bldg

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 X16005

---

---

**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.**