

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.

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

21345
Do not use this space.

JUL 10 1939

1. PLACE OF DEATH

(a) County JACKSON 2 Registration District No. 399
(b) Township RAW Primary Registration District No. 1002 Registered No. 2613
(c) City RAMSAS CITY 1 (d) Street No. 1422 SUMMIT 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 22 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

624 MRS. MARY LOUISE BEDOLL KIRKLEY
(a) Residence, No. 1422 SUMMIT 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 ROBERT M. KIRKLEY
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL-23-1881
7. AGE YEARS 58 MONTHS 2 DAYS 5 If LESS than 1 day, _____ hrs. or _____ min.
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) ILLINOIS 1

FATHER 13. NAME ALEX BEDOLL 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ILLINOIS

MOTHER 15. MAIDEN NAME LUCY STANT 1

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

17. INFORMANT (ADDRESS) MR ROBERT M KIRKLEY 1422 SUMMIT STREET

18. BURIAL, CREMATION, OR REMOVAL PLACE MT MORIAH DATE JUNE-30-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) D.W. NEWCOMER'S SONS 1401-13 BRUSH CREEK BLDG 629

20. FILED 629 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JUNE-28-1939

22. I HEREBY CERTIFY, That I attended deceased from June 1930 to June 27 1939
I last saw her alive on June 27, 1939 Death is said to have occurred on the date stated above, at 5:30 A.

The principal cause of death and related causes of importance were as follows:
Perniciou anemia chronic
710

Date of onset 1930

Other contributory causes of importance:
Name of operation none Date of _____
What test confirmed diagnosis? fat Was there an autopsy? _____

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? no (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) D. P. K... M. D.
(Address) 615 Angella Bldg

2-6
ll
9-8

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 E. M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K. C. Mo

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.