LEC'D AUG 7 1939

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

24450
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. 2663
(c) or City KANSAS CITY — (d) Street No. TRINITY HOSPITAL 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 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 245 MRS. MARRIETTA CAWOOD HOAGLAND
(a) Residence, No. 7019 MONTGALL 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: FE
4. COLOR OR RACE: WH
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF JNO M HOAGLAND
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) SEPT 14-1905
7. AGE: YEARS 33 — MONTHS 9 — DAYS 18 — 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) SCHELL CITY MO

FATHER
13. NAME MITCHELL B CAWOOD
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CLAIBORNE CO TENN

MOTHER
15. MAIDEN NAME MERTIE E KABRICK
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) OAK GROVE MO

17. INFORMANT (ADDRESS) JNO M HOAGLAND 7019 MONTGALL
18. BURIAL, CREMATION, OR REMOVAL PLACE SCHELL CITY MO JULY 3 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) D W NEWCOMERS SONS 1401 BRUSH CREEK BLVD
20. FILED July 3 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 2 1939
22. I HEREBY CERTIFY, That I attended deceased from June 25, 1939, to July 2, 1939
I last saw ~~her~~ alive on July 2, 1939. Death is said to have occurred on the date stated above, at 5:35 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bilateral Hydronephrosis acute By to nephritis	
139	

Other contributory causes of importance:

Name of operation Ovarian cyst non malig Date of July 26-38
What test confirmed diagnosis? Autopsy Was there an autopsy?
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) H S Hickok, M. D.
(Address) 1025 Realto Bldg

(Licensed Embalmer'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.

...WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

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