

WRITE PEANUT, WITH UNPAID 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

REC'D AUG 7 1939

24551
 Do not use this space.

1. PLACE OF DEATH

(a) County Dickson Registration District No. 399
 (b) Township Dickson Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 1209 1/2 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.

Registered No. 2764

2. PRINT FULL NAME

(a) Residence, No. 2705 Brooklawn 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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-8-1873
 7. AGE YEARS 66 MONTHS 2 DAYS 28 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-6 1939
 22. I HEREBY CERTIFY, That I attended deceased from 4-14 1939 to 7-6 1939
 I last saw him/her alive on 7-6 1939 Death is said to have occurred on the date stated above, at 8:30 p.m.

The principal cause of death and related causes of importance were as follows:

Portal Cirrhosis of Liver 12/1/38 Date of onset

Other contributory causes of importance:

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

FATHER 13. NAME Unknown 9

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Harland G. Banger
2705 Brooklawn

18. BURIAL, CREMATION, OR REMOVAL PLACE Brooklawn Cem. DATE 7-10 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Sigelman & Sons
2705 Brooklawn

20. FILED July 10 1939 M. H. Crowe Local Registrar.

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) 2705 Brooklawn

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.