

1939 AUG 7

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

24621
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Rawley Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. St. Vincent's Hosp. 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

(a) Residence, No. 23rd Coleridge - St. Vincent (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13, 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
1 1 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
 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) Kc Mo.

FATHER 13. NAME unknown

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

MOTHER 15. MAIDEN NAME MARY MUFICH

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Kansas

17. INFORMANT (ADDRESS) Record Clerk St. Vincent's Hosp.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 7-14-39

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

20. FILED July 14, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 14, 1939

22. I HEREBY CERTIFY, That I attended deceased from 7/13, 1939, to 7/14/39, 1939. I last saw him alive on 7/13, 1939. Death is said to have occurred on the date stated above, at 4:30 a.m.

The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage & New born Date of onset 7/13/39
16 hrs

Other contributory causes of importance:
lung pneumonia

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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? _____ (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?
 If so, specify _____ (Signed) Joseph Kester, M. D.
 (Address) 612 Professional

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.

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.