REC'D AUG 22 1939

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

25830
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson — Registration District No. 403

(b) Township ~~Kaw~~ BROOKING — Primary Registration District No. 5557 — Registered No.

or

(c) City ~~Kansas City~~ — (d) Street No. Municipal Farm 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.

652

2. PRINT FULL NAME Estil D. Kring

(a) Residence, No. 3923 Garfield 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 10, ✓

7. AGE — YEARS: 41 — MONTHS: ✓ — DAYS: ✓ — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Stationery
9. Industry or business in which work was done, as saw mill, bank, etc. Fireman
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) Cassville Missouri

FATHER

13. NAME Henry Clay Kring
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Nora Link
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cassville Missouri

17. INFORMANT (ADDRESS) Mrs. H. D. Westenhauer 3923 garfield

18. BURIAL, CREMATION, OR REMOVAL
PLACE Monett, Mo. DATE July 29, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) QUIRK & TOBIN CO. Kansas City, Mo.

20. FILED 7-28, 1939 D M Eubank
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 4 A m.
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia — Date of onset

Other contributory causes of importance:

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? ..... 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) [signature], M. D.
(Address) [signature]

(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.

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 Maurice McDurk

Licensed Embalmer No. 2226

P. O. Address KC. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co with the above constitutes grounds for revocation of license.).

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

25830

Do not use this space.

1. PLACE OF DEATH
   (a) County Jackson — Registration District No. 403
   (b) Township Brooking — Primary Registration District No. 5527 — Registered No.
   (c) City — (d) Street No. — 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 Estil D. Kring
   (a) Residence, No. — 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 10 (1898)

7. AGE — YEARS: 40 — MONTHS: 7 — DAYS: 16 — If LESS than 1 day, ...hrs. or ....min.

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

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

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE — DATE — 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7-28, 1939 D M Eubank, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-26, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

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? ..... 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) Russell W. Kerr, M. D.
(Address) K. C. Mo

SUPPLEMENTARY

1939
S-25830