

AUG 7 1939

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

27126
Do not use this space.

1. PLACE OF DEATH

(a) County Wernon Registration District No. 875
(b) Township Washington Primary Registration District No. 6162
(c) City Stall or Keap #3 Registered No. 184
(d) Street No. Stall Keap #3 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 0 yrs. 1 mo. 7 da. (f) How long in U. S., if of foreign birth? yrs. mo. da.

2. PRINT FULL NAME

(a) Residence, No. 163 Mary Evertson St.
Lees Summit (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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 15, 1863

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
76 2 6

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) George Iowa

13. NAME George Slonicker

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

15. MAIDEN NAME Martha Manard

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

17. INFORMANT (ADDRESS) Blorp Records

18. BURIAL, CREMATION, OR REMOVAL Lees Summit DATE 7-23

19. FUNERAL DIRECTOR (NAME) (ADDRESS) N. B. Langstaff
Lees Summit Mo.

20. FILED 7/24 19 Allen V. Hays
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, that I attended deceased from June 19, 1939, to July 21, 1939

Last saw her alive on July 20, 1939. Death is said

to have occurred on the date stated above, at 7:52 A.M.

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

Hypostatic pneumonia 7/10/39

Fracture-neck of left femur 7/16/39

Other contributory causes of importance:
Hypertensive cardio-vascular
renal disease
Generalized arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 7/16, 1939

Where did injury occur? On hospital ward - Manard
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fell on ward of hosp.

Nature of injury Fracture-neck of left femur

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Wm. J. Cooper, M. D.

(Address) Nebraska, Mo.

RECEIVED

District Health Officer No. 7₆

District File Number 7-39-1134

Date Filed 8-4-39

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.