

REC'D SEP 6 1939

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

28410
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Raw Primary Registration District No. 1002
(c) City Rivers City (d) Street No. Conley Clinical Hospital Registered No. 3412
(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. 517 IDA MAY CAIN St. Brunswick, Mo.
(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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

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

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

7. AGE YEARS 64 MONTHS DAYS If LESS than 1 day, hrs. or min.

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. at home
10. Date deceased last worked at this occupation (month and year) August 28 39
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 0

FATHER 13. NAME 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 1

MOTHER 15. MAIDEN NAME

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

17. INFORMANT M. V. Craster (ADDRESS) 1720 Summit (City)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR Meyer Funeral Home (ADDRESS) Brunswick, Mo.

20. FUNERARY HOME Aug 31 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-31-1939

22. I HEREBY CERTIFY, That I attended deceased from 8-29-1939, to 8-31-1939
I last saw her alive on 8-31-1939. Death is said to have occurred on the date stated above, at 9:15 p.m.
The principal cause of death and related causes of importance were as follows:

Acute Pulmonary Edema
Date of onset

Other contributory causes of importance:
Arteriosclerosis with Hypertension

Name of operation Autopsy Date of 8-31
What test confirmed diagnosis? Autopsy Was there an autopsy? no

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 1
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify Dr. J. J. Graham, D.
(Signed) Dr. J. J. Graham, D.
(Address) 811 Chamber Bldg.

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, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

L. E. _____

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No.
 (b) Township Tow Primary Registration District No. Registered No. 3412
 (c) City K. C. Mo (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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Ida May Cox 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	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) <u>Brunswick</u> (STATE OR COUNTRY) <u>Mo.</u>				
FATHER	13. NAME <u>Axley Cox</u>			
	14. BIRTHPLACE (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME <u>Mary</u>			
	16. BIRTHPLACE (CITY OR TOWN) <u>Mo.</u> (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Brunswick Mo.</u> DATE <u>Sept 3</u> 19 <u>39</u>				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED <u>8/31</u> 19 <u>39</u> <u>M. M. Kerow</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 31 1939

22. I HEREBY CERTIFY, That I attended deceased from 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) M. D. (Address)

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. *28410*

Registrar's No. *3412*

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County *Jackson*
(b) City or town *K.C.*
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Ida M. Cain

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex *F*

5. Color or race *W*

6. (a) Single, widowed, married, divorced *M*

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

MOTHER FATHER

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) *8/31/29* (b) *M. M. Browne*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

20. DATE OF DEATH Month *Aug. 21* - *29* -
year hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death
*Acute pulm edema -
arteriosclerosis -
Due to Hypertension -
Acute myocarditis*

Other conditions (Include pregnancy within 3 months of death) *q3w*

Major findings: Of operation *Laparotomy 8-31-29*

Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) While at work? (e) Means of injury.

23. Signature (M. D. or other) Address Date signed

SUPPLEMENTARY
Exp. 10/29/29

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD