DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31544

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3642

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community ____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 5629 - Euclid (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Lena Gnexkow 512

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Aug (Month) 14 (Day) 1866 (Year)

8. AGE: Years 73 Months 1 Days 2 If less than one day ____ hr. ____ min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Walruff 6
13. Birthplace Germany (City, town, or county) 6 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bernard Gnexkow

(b) Address 5637 Euclid

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-39 (Month) (Day) (Year)

(c) Place: burial or cremation St Mary Center

18. (a) Signature of funeral director Theisen Funeral

(b) Address 2512 Holmes

19. (a) Sept 18 1939 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16 year 1939 hour 8 minute 15 P M.

21. I hereby certify that I attended the deceased from ~~Sept 16~~ July 3, 1939 to Sept 16, 1939 that I last saw her alive on Sept 16, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Sclerotic Myocarditis — Duration 3 yrs
Cardiac & Mitral Stenosis
Diabetic & Mitral Vegetations
Chronic Sclerotic Endocarditis

Due to ____

Other conditions none (Include pregnancy within 3 months of death)

Major findings: Of operations ____

Of autopsy as above

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)

While at work? no (e) Means of injury no

23. Signature [signature] (M. D. or other)

Address 814 Prof Bldg Date signed 9-16-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

MARGIN RESERVED FOR BINDING

Rev. 5-17-39 1 X19511

7.3X 31- 73-30

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

31544
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township — Primary Registration District No. 1002 — Registered No. 3642
(c) City K. C. — (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 512 Lena Gnefkow
(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

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

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

7. AGE — YEARS: 73 — MONTHS: 1 — DAYS: 2 — 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)

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 9/18 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-16, 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) [signature], M. D.
(Address) Prof. Bldg. K. C.

SUPPLEMENTARY

WHITE PLAINLY, WITH UNFADING 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.

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

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