

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.

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

31647
Do not use this space.

50 OCT 18 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
 (b) Township Bay Primary Registration District No. 100 Registered No. 3745
 (c) City St. Charles (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. 656 Olive St. St. Charles 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) September 25 1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 7 mos. 15 days

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. child
 9. Industry or business in which work was done, as saw mill, bank, etc. child
 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) Kansas City Mo.

13. NAME Robert Warner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

15. MAIDEN NAME Vera Huntington

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rose Dale Kansas

17. INFORMANT (ADDRESS) St. Vincent's Hosp. St. Charles Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE German Cem. DATE Sept 26 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rose Henderson St. Charles Mo.

20. FILED 9/26/39 M. M. Brown Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19____

22. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1939, to Sept 25, 1939.
 I have been alive on Sept 25, 1939. Death is said to have occurred on the date stated above, at 7:00 a.m.
 The principal cause of death and related causes of importance were as follows:

Premature Birth
159
 Other contributory causes of importance: Born about 3th mo.

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. R. Foster, M. D.
 (Address) 1529 Lester

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.

*Still have
no embalming*

Signed *John B. Camp*

Licensed Embalmer No. *9955*

P. O. Address *J. C. Moore*

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.