DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34879

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3854

NOV 14 1939

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K C Gen Hospt (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 39 years

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. 2419 McGee (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Chas Zaring (652)
3. (b) If veteran, name war No
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased March (Month) 30 (Day) 1886 (Year)

8. AGE: Years 53 Months 6 Days 1 If less than one day ____ hr. ____ min.
9. Birthplace (City, town, or county) Md (State or foreign country)
10. Usual occupation Decorator
11. Industry or business
FATHER
12. Name Chas A Zaring
13. Birthplace (City, town, or county) Md (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Record Clerk
(b) Address K C Gen Hospt
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-39 (Month) (Day) (Year)
(c) Place: burial or cremation Elmwood
18. (a) Signature of funeral director Nellody McGilley
(b) Address Kcmo
19. (a) 10-5-39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 1 year 1939 hour 7 minute 15-8 M.
21. I hereby certify that I attended the deceased from Oct 1-39, 19__, to Oct-1-, 1939 that I last saw him alive on Oct-1-39, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Right apical Tuberculosis with Cavitation — Duration
Due to Bilateral Acute Tuberculous Bronchopneumonia
Due to None
23
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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)
(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 P F De Maria MD (M. D. or other)
Address Supt K C Gen Hospt Date signed

(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.

I X19511

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 wit the above constitutes grounds for revocation of license.)

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