

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

34936

Do not use this space.

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 399
(b) Township RAW Primary Registration District No. 1002 Registered No. 3911
(c) City KANSAS CITY (d) Street No. 4300 HIGHLAND 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 25 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MISS HANNAH MARIE KRATZER
(a) Residence, No. 4300 HIGHLAND 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 FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT-10-1863

7. AGE YEARS 75 MONTHS 11 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME
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) OHIO

FATHER 13. NAME SAMUEL KRATZER

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

MOTHER 15. MAIDEN NAME MELINDA DRANE

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

17. INFORMANT MRS. RUTH E. CLARK
(ADDRESS) 4300 HIGHLAND

18. BURIAL, CREMATION, OR REMOVAL PLACE MEMORIAL PARK DATE OCT-10-1939

19. FUNERAL DIRECTOR (NAME) D.W. NEWCOMER'S SONS
(ADDRESS) 1401 BRUSH CREEK BLVD

20. FILED 10/10 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) OCT-9 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 6 1939 to Oct 9 1939

I last saw her alive on Oct 8 1939 Death is said

to have occurred on the date stated above, at 7:30 A.M.

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

Cerebral hemorrhage Date of onset Oct 6-39
82a'

Other contributory causes of importance:

arteriosclerosis 5yrs

Name of operation _____ Date of _____

What test confirmed diagnosis? clinical 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 _____

Nature of injury _____

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

If so, specify _____

(Signed) J. E. Schoen, M. D.

(Address) 243 W. W. Bldg

9:30-5:45

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..... *H. O. Newcomer, Jr.*

Licensed Embalmer No. *41043*

P. O. Address *Kansas City, Mo.*

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.