

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 38520Registration District No. 399Primary Registration District No. 7002Registrar's No. 4284

## 1. PLACE OF DEATH:

(a) County JACKSON **2**  
 (b) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1017 ARNO ROAD  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether  
 In this community 20 YEARS  
 years, months or days)

3. (a) PRINT FULL NAME MRS. SARAH LEONA PRAMER **654**3. (b) If veteran, name war —NO 3. (c) Social Security No. —NO4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife MR. JACK PRAMER 6. (c) Age of husband or wife if alive UNKNOWN years7. Birth date of deceased OCTOBER - 12 - 1879  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
60 0 27 hr. min.9. Birthplace PRESCOTT KANSAS  
(City, town, or county) (State or foreign country)10. Usual occupation AT HOME **1**

11. Industry or business \_\_\_\_\_

12. Name BLAKE **1**13. Birthplace BROOKLYN NEW YORK  
(City, town, or county) (State or foreign country)14. Maiden name MANDA LAWSBERRY15. Birthplace CANADA  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Dwain G. Gumbert(b) Address 1017 ARNO ROAD17. (a) CREMATION (b) Date thereof NOV-9-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation DW. NEWCOMER'S SONS(a) Signature of funeral director D. W. Newcomer's Sons(b) Address 1401 BRUSH GREEN BLDG(a) 11-9-1939 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON  
 (c) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1017 ARNO ROAD  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8th  
year 1939 hour 2 minute A. M.21. I hereby certify that I attended the deceased from January  
1939, to Nov 8th, 1939;  
that I last saw her alive on Nov. 7th, 1939;  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Occlusion **2 months**  
DurationDue to Cerebral Arterio-  
sclerosis.Due to 94BOther conditions Coronary Sclerosis **2 yrs.**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:

(Ident. suicide, or homicide (specify)) \_\_\_\_\_

(a) 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? 1 (e) Means of injury \_\_\_\_\_23. Signature D. W. Newcomer's Sons (M. D. or other) \_\_\_\_\_Address 1408 Waldheim Date signed 11/8/39

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**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 Emile M. Calhoun

Licensed Embalmer No. 3506

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.**