

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **42306**Registration District No. **399**Primary Registration District No. **1002**Registrar's No. **4715**

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. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 days**
same (Specify whether years, months or days)
 In this community _____

3. (a) PRINT FULL NAME **Santmyres infant 535**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F.** 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 **Dec. 7th 1939**
(Month) (Day) (Year)8. AGE: Years _____ Months _____ Days **4** If less than one day _____ hr. _____ min.9. Birthplace **K.C. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Joe Santmyres**13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name **Edith Carter**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Joe Santmyres**(b) Address **2933 Mercier**17. (a) (Burial, cremation, or removal) _____ (b) Date thereof **12-11-39**
(Month) (Day) (Year)(c) Place: burial or cremation **St. Joseph - Sarsaparilla**18. (a) Signature of funeral director **W. J. Dyer**(b) Address **1111 S. 1st St.**19. (a) **Dec. 12, 1939** (b) **M. M. Crome**
(Date received local registrar) (Registrar's signature)

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. **2932 Mercier**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **11th**
year **1939** hour **3** minute **30** A.M. M.21. I hereby certify that I attended the deceased from **Dec. 8th**
1939 to **Dec. 11th 39**;
that I last saw her alive on **Dec. 11th, 1939**, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death **Peritonitis following** Duration _____
repair of congenital diaphragmatic
herniaDue to **1572**

Due to _____

Other conditions **Bullous lesions over entire**
(Include pregnancy within 3 months of death)
body, possibly staphylococci,Major findings: _____ PHYSICIAN _____
Of operations _____Of autopsy **See above**
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Dr. J. DeMoria M.D.** (M. D. or other) _____Address **Supt. K.C. Gen. Hosp.** Date signed **12-11-39**

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 _____

Harvey Roy, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 2810

P. O. Address 1107 - St. Louis

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.