

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4871

*12 1939*

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Trinity Lutheran Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Day  
 (Specify whether years, months or days)  
 In this community 47 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 339 Lawn Ave.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Mrs. Rella G. Custenborder 735

3. (b) If veteran, name war

None

3. (c) Social Security No.

None

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fred B. Custenborder

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Apr. 15, 1872  
 (Month) (Day) (Year)

8. AGE: Years 67 Months 8 Days 9  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

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

12. Name Unknown

18. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Fred B. Custenborder

(b) Address 339 Lawn Ave. K.C. Mo.

17. (a) Burial (b) Date thereof Dec. 26-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, K.C. Ks.

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd. K.C. Mo.

19. (a) Dec. 26, 1939 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 24  
 year 1939 hour 8 minute 18 P.M.

21. I hereby certify that I attended the deceased from 12-22-1939  
 \_\_\_\_\_, 19\_\_\_\_, to 12/24 \_\_\_\_\_, 1939

that I last saw her alive on 12/24, 1939  
 and that death occurred on the date and hour stated above.

Immediate cause of death 10 triangulated  
irregular pericarditis, left side, 24 hrs.  
2. Bacterial pneumonia, terminal  
3. Due to Coronary sclerosis

Duration

Due to \_\_\_\_\_  
12/24

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy Those above

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? \_\_\_\_\_

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

23. Signature M. M. Crowe (M. D. or other)

Address County Hospital Date signed 12/24/39

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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 W. Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. 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.**