

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.

JAN 26 1940

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1110
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 95
 (c) City Kansas City, Mo (d) Street No. Wesley Hospital 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 1 yrs. 5 mos. 5 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Eva E Gore 600
 (a) Residence, No. Casa Co St. Bellton, Mo., R.F.D.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 19, 1894

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>45</u>	<u>2</u>	<u>18</u>	

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) Dec 1939

11. Total time (years) spent in this occupation 21

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

FATHER

13. NAME Henry Wood

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

MOTHER

15. MAIDEN NAME Frances Eastman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Hampshire

17. INFORMANT (ADDRESS) Wilbur Gore
Bellton Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Raymore Mo DATE 1/10 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. R. George & Sons
Bellton Mo

20. FILED Jan 8 19 40 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 7 19 40

22. I HEREBY CERTIFY, that I attended deceased from Jan 2 1940 to Jan 7 1940
 I last saw him alive on Jan 7 1940. Death is said to have occurred on the date stated above, at 11 a.m.
 The principal cause of death and related causes of importance were as follows:
Pulmonary Congestion
acute toxic myocarditis
degenerated Pericardial lining
post-operative
fluid electrolyte imbalance
renal stasis
 Other contributory causes of importance:
See above

Name of operation cardiac autopsy date of Jan 2
 What test confirmed diagnosis? fluid electrolyte Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury no, 19 no
 Where did injury occur? no
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. no

Manner of injury no
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify no
 (Signed) J. G. Mackey, M. D.
 (Address) Kansas City, Mo

9700

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,

Berry W. Thacher

or by

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

Signed

Berry W. Thacher

Licensed Embalmer No.

3944

P. O. Address

Belton, 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1110 ⁷
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. 75
(c) City..... (d) Street No. Wesley Drapt 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 375 mos. ds. 0 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bora E. Hove

(a) Residence, No. Belton Mo 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 Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1/8 19 40 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 7, 1940

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Pulmonary, Acute Myocardial Infarction, Peritonitis, Bilary Obstruction, Cholelithiasis
Date of onset

Other contributory causes of importance: 1940

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify (Signed)....., M. D.

(Address).....

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

