

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
STANDARD CERTIFICATE OF DEATH
1002

Registration District No. **399**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Kansas **1**
(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 1 day
(Specify whether
In this community 53 years
years, months or days)

3. (a) PRINT FULL NAME MATT NIBBLER **146**

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

4. Sex Male 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 April 2 - 1872
(Month) (Day) (Year)

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

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

10. Usual occupation Construction Work

11. Industry or Business _____

12. Name John Nibbler

13. Birthplace MO
(City, town, or county) (State or foreign country)

14. Maiden name Emma Mark

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

16. (a) Informant's own signature Record Clerk

(b) Address K.C. Gen. Hosp

17. (a) Burial (b) Date thereof 1-22-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlaw

18. (a) Signature of funeral director Wm. A. Johnson

(b) Address K.C. Gen. Hosp

19. (a) Jan. 22, 1940 (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. Helping Hand Institute
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11th
year 1940 hour 11 minute 45 P.M. M.

21. I hereby certify that I attended the deceased from Jan. 10th, 1940, to Jan. 11th, 1940; that I last saw him alive on Jan. 11th, 1940, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia; pulmonary congestion and edema

Due to Cardio vascular Renal Disease

Due to _____

Other conditions Uremia, clinical **121**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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? _____

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

23. Signature P. De Maria M.D. (M. D. or other)

Address Supt. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Wm A. Lohmeyer

Licensed Embalmer No. 3089

P. O. Address KE MD

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.