. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5456

FILED MAR 399 1940

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 681

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: 6829 Paseo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community: Life

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. 6829 Paseo
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years

3. (a) PRINT FULL NAME: Mrs Martha A. Sommer

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Fe

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Chas, F. Sommer

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

7. Birth date of deceased: 2-27-1868 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
71	11	16	hr. min.

9. Birthplace: Doniphon County, Kans. (City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business: _____

FATHER
12. Name: John Pauly
13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: No Record
15. Birthplace: No Record (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Michael Hund
(b) Address: 6829 Paseo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 16, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Atchison, Kans

18. (a) Signature of funeral director: Thos. E. Quirk
(b) Address: 4316 Troost Ave

19. (a) Feb. 14, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13 day Feb. year 1940 hour 10/10 p.m. minute _____ M.

21. I hereby certify that I attended the deceased from November, 1939, to Febr 13, 1940, that I last saw her alive on Febr. 13, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Rheumatic Heart disease, Mitral stenosis	
Due to: Inflammatory rheumatism.	
Due to:	
Other conditions: Cardiac failure (Include pregnancy within 3 months of death)	

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:
(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: M. Bornreuter (M. D. or other) M.D.
Address: 709 E 62 Str. K. C. Mo Date signed 2-14-40

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas E. Turk

Licensed Embalmer No. 3775

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.