

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

1940

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

17456
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Rav Primary Registration District No. 1002 Registered No. 1983
 (c) City Kansas City (d) Street No. St. Joseph Hosp 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Vernie E. Dick (Mrs. Vernie E. Dick)
 (a) Residence, No. Carrollton, 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-24-1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
61 3 18

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Whelch Grove Iowa

FATHER
 13. NAME James C. Hunter
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
 15. MAIDEN NAME Amanda Pritchell
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Carl Dick Wakenda Mo. R.P. 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Removal Carrollton 5-12-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stanley Fum Home Carrollton Mo

20. FILED May 13, 1940 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-12-40 19

22. I HEREBY CERTIFY, That I attended deceased from 4-29-40, 19, to 5-12-40, 19.
 I last saw her ex alive on 5-12-40, 19. Death is said to have occurred on the date stated above, at 8:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of the Breast
Metastases Lung Liver and adrenals
Bilateral Hydrothorax
 Other contributory causes of importance: 50

Date of onset

Name of operation Autopsy Date of Autopsy
 What test confirmed diagnosis Autopsy Was there an autopsy Yes

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) Russell W. Ford, M. D.
 (Address) Carrollton

Next to Name (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 Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.