

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20719
2336
Registrar's No. _____

Registration District No. 10991 Primary Registration District No. 1002

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:
Trinity Lutheran Hospital
(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) 2 days

8. (a) PRINT FULL NAME Daniel Louis Sarli 640

8. (b) If veteran, name war none 8. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 5, 1940
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 2 If less than one day
hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER { 12. Name Louis B. Sarli 6

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

14. Maiden name Ruth I. Spong

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

16. (a) Informant Louis B. Sarli

(b) Address 4015 Wyoming

17. (a) Burial (b) Date thereof June 7, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) June 7, 1940 (b) M. M. Crew
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4015 Wyoming
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7th
year 1940 hour 10 minute 53 P.M.

21. I hereby certify that I attended the deceased from July 5-1940
_____ 19____ to July 7th 19____

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death:
1-Septicemic hemorrhage 2 days
2-Bilateral adrenal
Due to hemorrhage
16/11

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy yes

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 1

23. Signature Tom J. Smith (M. D. or other)
Address Trinity Hosp Date signed 6/7/40

Duration
Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.