

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20770

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2387

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3133Gilliam Rd.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether  
In this community Unknown  
years, months or days)

8. (a) PRINT FULL NAME Charles B. HERRMANN. 655

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

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

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

7. Birth date of deceased Unknown.  
(Month) (Day) (Year)

8. AGE: About 45 Years Months Days If less than one day hr. min.

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

10. Usual occupation Upholster

11. Industry or business

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Veterans Administration.

(b) Address City

17. (a) Removal (b) Date thereof 6/11/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leavenworth Kansas

18. (a) Signature of funeral director Melody-McGilley.

(b) Address K. C. Mo.

19. (a) June 11, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1331A Troost Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 Day 10 Year 40  
hour \_\_\_\_\_ minute 50 PM.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Chronic fibrous myocardium

Due to Chronic Myocardial Infarction 92c

Due to Coronary Thrombosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? 361

(Specify type of place) \_\_\_\_\_ While at work (e) Means of injury \_\_\_\_\_

23. Signature Russell W. Jones (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

9  
9  
1

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**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. 2995

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.**

JUL 17 1940

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399

(b) Township Kaw Primary Registration District No. 1002

(c) City Kansas City (d) Street No. \_\_\_\_\_ 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 Charles B. Herrmann

(a) Residence, No. \_\_\_\_\_ 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 \_\_\_\_\_ 4. COLOR OR RACE \_\_\_\_\_ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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.
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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) Chicago (STATE OR COUNTRY) Illinois

FATHER

13. NAME Charles B. Herrmann

14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME Ada Frances

16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED July 1, 1940 M. M. Crowe Local Registrar.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 6, 1940

22. I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_ 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:

Other contributory causes of importance: \_\_\_\_\_

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) \_\_\_\_\_

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

TEMPORARY

S-20770