

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

21271  
Do not use this space.

JUL 12 1940

1. PLACE OF DEATH

(a) County Burchman Registration District No. 85  
 (b) Township St. Joseph Primary Registration District No. 1001  
 (c) City St. Joseph (d) Street No. State Hosp. #2 St. Mo.  
 (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. 1 mos. 26 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

Registered No. 676

2. PRINT FULL NAME

(a) Residence, No. 620 Ben F. Parks St. Mo.  
State Hospital #2 (Usual place of abode, if no street address, write county or city)  
Kansas City Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX mule 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) separated  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF no information  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 19, 1900  
 7. AGE YEARS 39 MONTHS 9 DAYS #1 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. garage mechanic  
 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 34

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 20 1940  
 22. I HEREBY CERTIFY That I attended deceased from 4/7/35 1940, to 6-20 1940  
 I last saw him alive on June 20, 1940 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:

syphilitic meningitis, encephalitis Date of onset ?  
24

Other contributory causes of importance: Perforation of cecum - sudden  
(probably from eating glass)  
 Name of operation none Date of ?  
 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? NO  
 If so, specify .....  
 (Signed) J. T. O'Dell M. D.  
85 (Address) St. Hospital #2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Ca.  
 FATHER 13. NAME No information  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No information  
 MOTHER 15. MAIDEN NAME No information  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?  
 17. INFORMANT Jackson Co. Court (ADDRESS)  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Kansas City Mo. DATE June 25, 1940  
 19. FUNERAL DIRECTOR (NAME) Dodge Bros. (ADDRESS) Kansas City Mo.  
 20. FILED June 24, 1940 J. T. O'Dell Local Registrar.

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.

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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.....

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.**