S. No. 2
—11-10-39
. 5-17-39
I X21492

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

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24176

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2786

1. PLACE OF DEATH: 1

(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: K.C.Gen.Hospital No.1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether

In this community 40 years years, months or days)

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. 3410 Independence Avenue (If rural, give location)

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

3. (a) PRINT FULL NAME JOAN ZOOK 200

3. (b) If veteran, name war ----

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Jan. (Month) 17th (Day) 1867 (Year)

8. AGE: Years 73 Months 5 Days 1 If less than one day hr. min.

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

10. Usual occupation ~~Sandy Robinson~~ Unknown

11. Industry or business ? 9

FATHER
12. Name Unknown ?
13. Birthplace Unknown (City, town, or county) ? (State or foreign country) 9

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address K C Gen Hospt

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-10-40 (Month) (Day) (Year)

(c) Place: burial or cremation K C Amst Society

18. (a) Signature of funeral director Wm A Lohmeyer

(b) Address K C Gen Hospt

19. (a) July 10, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18th year 1940 hour 11 minute 30 A.M.

21. I hereby certify that I attended the deceased from 6-10-40, 19__, to 6-18-40, 19__; that I last saw her alive on 6-18-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of stomach

Due to 46

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

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 1

23. Signature P. F. De Maria MD (M. D. or other)

Address Supt. K.C. Gen. Hosp., K.C. Mo. Date signed

(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 Wm A Lohmeyer

Licensed Embalmer No. 3099

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.