

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24281**
2891
Registrar's No.

Registration District No. **399** Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution **701 West 75th Street**
(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) **40 YRS.**

3. (a) PRINT FULL NAME **Mrs. Pearl Mollie Marvin**
(b) If veteran, name war **No.** (c) Social Security No. **No.**

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

6. (b) Name of husband or wife **Dwight T. Marvin** 6. (c) Age of husband or wife if alive **21** years

7. Birth date of deceased **February 26 1897**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	43	4	23	hr. _____ min.

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

10. Usual occupation **at home**

11. Industry or business **X**

12. Name **P. R. Paul Brown**

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

14. Maiden name **Mollie Vogel**

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

16. (a) Informant **Dwight T. Marvin**

(b) Address **701 West 75th St., K. C., Mo.**

17. (a) **Burial** (b) Date thereof **7-20-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K.C., Mo.**

19. (a) **July 19, 1940** (b) **M. M. Crewe**
(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. **701 West 75th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **no.** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **18th**, year **1940**, hour **5:20** minute **A.** M.

21. I hereby certify that I attended the deceased from **Mar. 15**, 1940 to **July 18**, 1940

that I last saw her alive on **7-18-40**, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death **Malignant Hypertension**
Chronic Nephritis 1 yr.

Due to **131**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **NO**

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 _____

23. Signature **M. M. Crewe** (M. D. or other) _____

Address **1025 Rialto Bldg.** Date signed **7-19-40**

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

MOTHER FATHER

Dr. H. Anderson.

*Pres to Body
Friday 1 30*

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 *H. Anderson*

Licensed Embalmer No. *1413*

P. O. Address *P. O. Mo*

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.