

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27522**

SEP 5 1940
Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3155**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Feed Station, Kansas City
(c) Name of hospital or institution: Kansas City Municipal Tuberculosis
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month - 14 days
(Specify whether
In this community 3 yrs.
years, months or days) 675

3. (a) PRINT FULL NAME Perez, Theresa
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Mexican 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 19 - 1920
(Month) (Day) (Year)

8. AGE: Years 19 Months 6 Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Hernando, Alfores
13. Birthplace Mexico
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature K.C.M.T. Hospital
(b) Address Feed Station, Kansas City

17. (a) Burial (b) Date thereof 8-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Feed Stn

18. (a) Signature of funeral director Wm. A. Brown
(b) Address 120 W. 2nd St

19. (a) AUG. 7, 1940 (b) M. M. Brown
(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. 509 1/2 Walnut
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1940 hour 1 minute 40 P.M.
21. I hereby certify that I attended the deceased from June 12
1940 to July 29 1940
that I last saw her alive on July 29 1940
and that death occurred on the date and hour stated above

Immediate cause of death An advanced, bilateral pulmonary tuberculosis.
Due to 23
Due to _____
Other conditions Intestinal tuberculosis
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: None
Of operations None
Of autopsy None
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Wm. A. Brown (M.D. or other) 7/29/40
Address K.C.M.T. Hospital Date signed 7/29/40

Vi. 1948

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 Blaine E. Weichert
Licensed Embalmer No. 4075
P. O. Address 2332 Marquette St.

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.