

FILED SEP 16 1940

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

28268
Do not use this space.

1. PLACE OF DEATH *Clay* 1
(a) County *Clay* Registration District No. *198*
(b) Township *Fishing River* Primary Registration District No. *3011* Registered No. *122*
(c) City *Excelsior Springs* (d) Street No. *Excelsior Springs Hospital* 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 *300 Velma Utt*
(a) Residence, No. *Palo mo* 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 *Female* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF *Velma Utt*
(OR) WIFE OF *Vernie Utt*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 16-1910*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
30 4 26

OCCUPATION
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. *Housewife*
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray co. mo*

FATHER
13. NAME *Hope Norson*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray co mo*

MOTHER
15. MAIDEN NAME *Daisy Watson*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray co mo*

17. INFORMANT (ADDRESS) *Velma Utt Palo mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Anna* DATE *8-14 1940*

19. FUNERAL DIRECTOR (ADDRESS) *Alsbaugh & Cowley Palo mo*

20. FILED *8-12 1940* *Mrs. Ren M. Crucken* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 12 1940*

22. I HEREBY CERTIFY, That I attended deceased from *August 5 1940* to *Aug 12 1940*
I last saw her alive on *Aug 12 1940* Death is said to have occurred on the date stated above, at *8:00* m.
The principal cause of death and related causes of importance were as follows:
Peritonitis - following attempt to deliver baby @ approx. 144 M
vision - contracted pelvis - made delivery impossible.
Other contributory causes of importance:
Chloroform from child birth - contracted pelvis - Cesarean Pass.
Name of operation *Cesarean Pass* Date of operation *Aug 5 1940*
What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

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 *Peritonitis*
(Signed) *Ren M. Crucken* M. D.
(Address) *Excelsior Springs mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

RECEIVED
District Health Officer No. 8,
District File Number 9-9-40
Date Filed

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.)