

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

34439  
 Do not use this space.

NOV 1 1940

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. Lakeside 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. 9 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Josephine Isabelle Read Josephine Isabelle Read  
 (a) Residence, No. Brookfield, 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 6 - 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>59</u>	<u>11</u>	<u>8</u>	

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. .... None  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Buckkindsburg Mo  
 (STATE OR COUNTRY) Missouri

FATHER

13. NAME Chas H Read  
 14. BIRTHPLACE (CITY OR TOWN) Mo  
 (STATE OR COUNTRY) Ill.

MOTHER

15. MAIDEN NAME Josephine Edmonds  
 16. BIRTHPLACE (CITY OR TOWN) Ill.  
 (STATE OR COUNTRY)

17. INFORMANT D. C. Read  
 (ADDRESS) Brookfield Mo

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE South Hill Cemetery DATE Oct 17 1940

19. FUNERAL DIRECTOR (NAME) T. J. McBeth  
 (ADDRESS) Buckkindsburg Mo

20. FILED 10-14-40 1940 M. M. Brown  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 14 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 5 1940 to Oct 14 1940  
 I last saw him alive on Oct 14 1940 Death is said to have occurred on the date stated above, at ..... m.  
 The principal cause of death and related causes of importance were as follows:

<u>Intestinal Obstruction</u>	Date of onset <u>5 days</u>
Other contributory causes of importance: <u>Cancerous Left Ovary</u>	<u>49</u> <u>years</u>
<u>Gophers disease</u>	

Name of operation Splenectomy Date of Oct 7/40  
 What test confirmed diagnosis? Biopsy 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?  
 If so, specify George J. Conley M. D.  
 (Signed) F. J. 25 John Bell M.D.  
 (Address) Brookfield Mo

WHILE EXAMINING WITH IMPENDING 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.

I X16405

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>To Be</sup> ~~was~~ embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed J. F. McCall

Licensed Embalmer No. 1570

P. O. Address Broadbridge 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.