No. 2
-1-4-41
5-17-39
I X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20905

Registration District No. (111F) 1399

Primary Registration District No. 1002

Registrar's No. 2435

1. PLACE OF DEATH:

(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: Research Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 Days (Specify whether years, months or days)

In this community: 28 Yrs.

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. 1875 East 59th Street (If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country: Germany

3. (a) PRINT FULL NAME: Mrs. Sarah Vandewart

3. (b) If veteran, name war: No

3. (c) Social Security No. None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mr. Samuel Vandewart

6. (c) Age of husband or wife if alive: 83 years

7. Birth date of deceased: January (Month) 14 (Day) 1867 (Year)

8. AGE: Years 74 Months 5 Days 12 If less than one day: hr. min.

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

10. Usual occupation: At Home

11. Industry or business: Housewife

FATHER
12. Name: Cox
13. Birthplace: (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name: Julia Jaffa
15. Birthplace: (City, town, or county) Germany (State or foreign country)

16. (a) Informant: Mr. Samuel Vandewart

(b) Address: 1875 East 59th Street

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: June 27, 1941 (Month) (Day) (Year)

(c) Place: Burial or cremation: D. W. Newcomer's Sons

18. (a) Signature of funeral director: D. W. Newcomer's Sons

(b) Address: 1401 Brush Creek Blvd.

19. (a) 6/26/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26th year 1941 hour 3 minute 25 A. M.

21. I hereby certify that I attended the deceased from June 24, 1941, to June 26, 1941, that I last saw her alive on June 25, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	2 hours
Due to: Above	
Due to:	
Other conditions: Chronic myocarditis (Include pregnancy within 3 months of death)	

Major findings: Of operations: Fractured left humerus - surgical neck

Of autopsy:

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:

23. Signature: Agnes V. Zuber (M. D. or other) M.D.

Address: 600 Prof. Bldg. Date signed: 6-27-41

(Licensed Embalmer's Statement on Reverse Side)

93 B

Viewed

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K C Mo

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
—4-25-41
I X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 20905

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2435

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Research
(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)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Sarah Vande wark

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M-

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.
74			

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

10. Usual occupation _____

11. Industry or business _____

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

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

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 6/26/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26-41
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to _____

Due to _____

Other conditions Chr. Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operation Fract. lt. femur
Surgical neck

Of autopsy _____

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) Acc
(b) Date of occurrence 6-23-41
(c) Where did injury occur? 16 6 Jackson Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)
While at work? _____ (e) Means of injury Acc fall

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____