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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED MAY 11 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1949

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Polyclinic Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days.  
(Specify whether  
 In this community 28 years  
years, months or days)

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. 2122 Terrace St.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Maria Jesus Oliva

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 Valentin Oliva 6. (c) Age of husband or wife if alive unk years  
 7. Birth date of deceased May - 22 1894  
(Month) (Day) (Year)

8. AGE: Years 49 48 Months 11 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_ 9  
 13. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Valentin Oliva

(b) Address 2122 Terrace  
 17. (a) Burial (b) Date thereof 5-5-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director Blaine E. Wickett

(b) Address 2332 Monitor Place

19. (a) 5-4-44 (b) N. C. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1  
 year 1944 hour 2: minute 30 a. m.

21. I hereby certify that I attended the deceased from April 18, 1944 to May 1, 1944; that I last saw her alive on April 30, 1944; and that death occurred on the date and hour stated above.  
 Immediate cause of death Uremia

Due to Chronic Nephritis

Other conditions Diabetes  
(Include pregnancy within 3 months of death)

Major findings: 61  
 Of operations \_\_\_\_\_  
 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) \_\_\_\_\_  
 (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) (Specify means of injury)

23. Signature Dr. R. H. Roberts (M. D. or other) \_\_\_\_\_  
 Address 2301 Summit St. Date signed 5-3-44

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**