

No. 2  
-12-45  
5-17-39  
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1384  
35  
Registrar's No. \_\_\_\_\_

Registration District No. 1779

Primary Registration District No. 1002

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

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:  
ST JOSEPH HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

In this community 5 YEARS

3. (a) PRINT FULL NAME GEO P. UTT

3. (b) If veteran, name war NONE

3. (c) Social Security No. none

4. Sex MALE Color or race W

5. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS MINNETTE B. UTT

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased APRIL 6 1894  
(Month) (Day) (Year)

8. AGE: Years 52 Months 8 Days 28  
If less than one day hr. min.

9. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

10. Usual occupation PROPERTY OFFICER

11. Industry or business WAR ASSET ADMISTION

MOTHER FATHER

12. Name AMOS C. UTT

13. Birthplace ILLIONIS  
(City, town, or county) (State or foreign country)

14. Maiden name KATE MILEY

15. Birthplace ST LOUIS MO  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS MINNETTE B. UTT

(b) Address 4227 OLIVE

17. (a) Removal (b) Date thereof 1-5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST LOUIS MO

18. (a) Signature of funeral director Quirk & John

(b) Address 20 W. Linwood

19. (a) 1-5-47 (b) St. Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County JACKSON

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

(d) Street No. 4227 OLIVE  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day Saturday 47  
year 1947 hour 5 minute 45 M.

21. I hereby certify that I attended the deceased from Jan 1-4 to Death 19 47  
that I last saw him alive on 1-4 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Liver  
Due to Carcinoma of Sigmoid  
Duration 6 months  
1 yr

Other conditions 462  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations above  
Of autopsy nothing  
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 AMC (M. D. or other) MD  
Address MO Date signed 1-5-47

**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 *Howard W Farmer*

Licensed Embalmer No. *4134*

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.**