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.

REC'D APR 23 1938

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

9607
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 1072
(c) City Kansas City — (d) Street No. 2915 Olive 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 50 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Margaret E. Blakemore 425
(a) Residence, No. 2915 Olive St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Franklin Blakemore
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 4, 1839
7. AGE YEARS 98 MONTHS 7 DAYS 3 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Nashville Tennessee

FATHER
13. NAME John D. Gosse
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Baltimore Maryland

MOTHER
15. MAIDEN NAME Elizabeth Buie
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT (ADDRESS) Mrs. Alice Rea 2915 Olive, Kansas City, Mo.
18. ~~BURIAL~~, ~~CREMATION~~, OR REMOVAL PLACE Nashville, Tenn DATE March 9, 1938
19. FUNERAL DIRECTOR (ADDRESS) Wagner Fun'l Home 204 W. Linwood
20. FILED Mch 9, 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7, 1938

22. I HEREBY CERTIFY, That I attended deceased from March 3, 1938, to Mar. 7, 1938
I last saw her alive on Mar. 7, 1938. Death is said to have occurred on the date stated above, at 10:45 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bilateral ~~Bilat~~ Pneumonia Bronchial	Feb 27 '38
1070	

Other contributory causes of importance:
Senility

Name of operation none Date of —
What test confirmed diagnosis? Physical Exam 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
(Signed) Dr. E. R. Parker, M. D.
(Address) 1137 Rialto Bldg. K. C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

Porter

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 wit the above constitutes grounds for revocation of license.)