

REC'D JUN 9 1938

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

17301  
Do not use this space.

1938

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township ican Primary Registration District No. 1002 Registered No. 17301  
(c) City Camden city (d) Street No. 422 Gen Hosp 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

## 2. PRINT FULL NAME

(a) Residence, No. 5537 Virginia 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

## MEDICAL CERTIFICATE OF DEATH

3. SEX F. 4. COLOR OR RACE W. white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-12 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 4-26 1938, to 5-12 19386. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 2 1863I last saw her alive on 5-12 1938 Death is said to have occurred on the date stated above, at 12:55 a.m.7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 75 2 10

The principal cause of death and related causes of importance were as follows:

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

Relaxed Pelvic

Flux with Prostatic

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

Other contributory causes of importance:  
Postoperative death - exact cause not determined

13. NAME Wm F. Kan14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

Name of operation Hysterectomy Date of 5-10-38  
What test confirmed diagnosis? W Was there an autopsy? W

15. MAIDEN NAME Wm F. Kan16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

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.

17. INFORMANT (ADDRESS) Neura Clerk  
422 Gen Hosp KC Mo

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Miami, Oklahoma DATE May 15th, 193819. FUNERAL DIRECTOR (ADDRESS) Mrs. C. L. Forster  
918 Brooklyn Avenue, K.C. Mo.

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) P. J. De Maria, M. D.  
(Address) Super Gen Hosp KC

20. FILED May 13 1938 M. M. Brown  
Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 the above constitutes grounds for revocation of license.)**

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jackson  
Township H.C.  
City H.C. Gen. Hosp.

Registration District No. 399  
Primary Registration District No. 1002

File No. 17301-  
Registered No. 1995  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Martha E. Wilson

(a) Residence, No. 5537 Virginia St. Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
75 2 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. UNDERTAKER (ADDRESS)

20. FILED Aug 11 1935 McCrowe Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 12 1935

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the \_\_\_\_\_ stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Related pelvic floor carcinoma of uncertain origin  
Postoperative death - exact cause unknown  
Benign fibroid  
Hysterectomy  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: \_\_\_\_\_

Name of operation Hysterectomy Date of 5-10-35  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_

(Signed) P. J. De Maria M.D., M. D.  
(Address) Gen. Hosp.

SUPPLEMENTARY

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

1938  
S-17301