

REC'D SEP 13 1938

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

27819

Do not use this space.

3130

Registered No.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Yvan Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 2 C 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. ds.

2. PRINT FULL NAME

(a) Residence, No. Henry Saet St. (If nonresident, give city or town and State)
510 E 8th St
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-29-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
71 2 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 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) England

13. NAME Josiah Salt

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS) Mrs. Clarence K. Deppa

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenlaw DATE 8/6

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sheel Funeral Home
6606 Independence

20. FILED Aug 5 19 38 M. M. Crowe
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-4 19 38

22. I HEREBY CERTIFY, That I attended deceased from 7-31, 1938 to 8-4, 1938
 I first saw him alive on 8-4, 1938. Death is said to have occurred on the date stated above, at 4:30 PM.
 The principal cause of death and related causes of importance were as follows:

Cerebral Sclerosis Date of onset

Encephalomalacia

Other contributory causes of importance: 8703

Name of operation Date of
 What test confirmed diagnosis Autopsy Was there an autopsy? yes

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. F. De Maria, M. D.

(Address) Sept. 7 C. Gen Hosp. Kansas City

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

ALL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

27819-
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township _____ Primary Registration District No. 1002 Registered No. 3121
(c) City R.C. (d) Street No. 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. ds.

2. PRINT FULL NAME

(a) Residence, No. 512 1/2 - 8th 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

3. SEX M 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.
71 2 5

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.

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 8/5 38 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4 1928

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 date stated above, at _____ m.

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

Cerebral arteriosclerosis Date of onset _____

Encephalomalacia

Other contributory causes of importance: 82C

Name of operation _____ Date of _____

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. F. De Maria, M. D.

(Address) Gen. Hosp.

SUPPLEMENTARY

1938
S-27819