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.

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

DEC'D SEP 13 1938

28076
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City Kansas City, Mo
(d) Street No. Trinity Lutheran Hospital 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.

Registration District No. 399
Primary Registration District No. 1002
Registered No. 3387

2. PRINT FULL NAME Jacob C. Endicott (Endicott)
(a) Residence, No. 7608 ~~Xxxxxxxxxxxxx~~ Wornall 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs. Minnie Endicott

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Sept. 16, 1866

7. AGE: YEARS 71 | MONTHS 11 | DAYS 9 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Hardware
9. Industry or business in which work was done, as saw mill, bank, etc.: merchant
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): Kansas

FATHER
13. NAME: Henry Endicott
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Indiana

MOTHER
15. MAIDEN NAME: Lavernie Mayer
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

17. INFORMANT (ADDRESS): Mrs. Minnie Endicott, 7608 Wornall

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Moriah DATE Aug. 27 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS): R. V. LINDSEY & SONS, 3811 Broadway

20. FILED Aug 27, 1938 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Aug. 25, 1938

22. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1938, to Aug 25, 1938
I last saw him alive on Aug 25, 1938. Death is said to have occurred on the date stated above, at 9:40 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular Insufficiency	
9 2 a	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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? .....
If so, specify .....
(Signed) V. Ferrel M. D.
(Address) 500 W 74

(Licensed Embalmer's Statement on Reverse Side)

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 comp with the above constitutes grounds for revocation of license.)

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