

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

31491
 Do not use this space.

OCT 15 1938

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Jean Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 26 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. 3340 Tracy 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-30-1872
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 65 10 28
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W. W.
 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) Mo

FATHER 13. NAME Henry Mueller

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

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) De malleys 26 Gen Hosp KC Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. St. Marys DATE 9-30 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. F. O'Connell Co.

20. FILED 9/29 1938 M. D. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-28 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-27 38 to 9-28 38
 I last saw him alive on 9-28 38. Death is said to have occurred on the date stated above, at 3:15 PM
 The principal cause of death and related causes of importance were as follows:

Subar Pneumonia Date of onset
108
 Other contributory causes of importance:
Chronic Passive Con- gestion of liver

Name of operation..... Date of.....
 What test confirmed diagnosis?..... 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 1
 (Signed) P. A. De Maria, M. D.
 (Address) 26 Gen Hosp KC Mo

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.

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

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