

REC'D FEB 20 1939

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

1231
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. _____
 (b) Township Palmer Primary Registration District No. _____
 (c) City Ends Sta. Kansas City, Mo. (d) Street No. Speeds J. O. Hospital Registered No. 244
 (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 29 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 3717 E. 26th St 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 26, 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
31 3 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Plasterer
 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) 1936 11. Total time (years) spent in this occupation _____

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

FATHER 13. NAME Care, Joseph

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

MOTHER 15. MAIDEN NAME Bellier, Mary

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

17. INFORMANT (ADDRESS) K. C. M. T. B. Hospital
Ends Sta. Kansas City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Floral Hill DATE Jan 21, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bergman Funeral Home
4306 Milwaukee Blvd

20. FILED Jan 20, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 18 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-9-36, 19____, to 10-18-39, 19____
 I last saw him alive on 10-18, 1939. Death is said to have occurred on the date stated above, at 9⁰⁰ P. m.
 The principal cause of death and related causes of importance were as follows:

PULMONARY TUBERCULOSIS Date of onset _____
23
 Other contributory causes of importance: No PNEUMOTHORAX - PNEUMIA TOXIC HEPATITIS AND MIGRAITIS

Name of operation THORAPLASTY Date of _____
 What test confirmed diagnosis? Sputum 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?
No
 Signature: [Signature] M. D.
 Address: Kansas City, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Cause of death should be clearly supplied. Age should be stated EXACTLY. PHYSICIANS SHOULD STATE

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,

H. C. BERGMAN

or by

Registered Apprentice No., working under my personal supervision.

Signed.....

H. C. BERGMAN

Licensed Embalmer No.

2041

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.