

REC'D FEB 20 1939

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

1332

Do not use this space.

345

Registered No.

1. PLACE OF DEATH

- (a) County Jackson Registration District No. 1
(b) Township Law Primary Registration District No. _____
(c) City Kansas City (d) Street No. 514 Tracy 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

- 550 Mae K. Bynum
(a) Residence, No. 514 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 <u>Fe.</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 10 1893</u>		
7. AGE <u>45</u>	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>at home</u>	11. Total time (years) spent in this occupation.....	
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).....	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>	0
FATHER	
13. NAME <u>Sherman Bynum</u>	0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	0
MOTHER	
15. MAIDEN NAME <u>Ethel Cropp</u>	
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	
17. INFORMANT <u>Waltham Appleton</u> (ADDRESS) <u>514 Tracy</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Highland</u> DATE <u>Jan 27 1939</u>	
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Waltham Appleton</u> <u>1729 Lybia</u>	
20. FILED <u>Jan 27 1939</u> <u>M.M. Crowe, asst</u> Local Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 24 1939

22. I HEREBY CERTIFY That I attended deceased from 1-22-1939 to 1-24-1939
I last saw h. alive on 1-24-1939 Death is said to have occurred on the date stated above, at 8:30 a.m.
The principal cause of death and related causes of importance were as follows:
Acute Lobar pneumonia followed by cerebral edema
108
Date of onset _____

Other contributory causes of importance: _____

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) A. D. B. Adams, M. D.
(Address) 819 S. Judg. ave

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, _____

T. B. Watkins

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

T. B. Watkins

Licensed Embalmer No. *2889*

P. O. Address _____

1729 Lydia

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.