

REC'D MAR 9 1939

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

5391

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Jackson Primary Registration District No. 1002  
(c) City J.C. (d) Street No. 615 29th St Registered No. 590  
(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. 615 29th 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 ma 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 23 1886

7. AGE YEARS 52 MONTHS 1 DAYS 17 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Professional  
9. Industry or business in which work was done, as saw mill, bank, etc. man  
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) New York

FATHER 13. NAME unknown

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

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Ray M. Meekhead

18. BURIAL, CREATION, OR REMOVAL PLACE St. Joseph Mo. DATE 2-13-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) St. Ignace

20. FILED 2912 1939 M. H. Brown  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/10/39 . 1939

22. I HEREBY CERTIFY That I attended deceased from 1939 to 1939

I last saw h. .... alive on 8:40 A 19..... Death is said to have occurred on the date stated above, at 8:40 A.

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

Paralytic and poisoning Date of onset

Other contributory causes of importance: W

Name of operation Autopsy Date of 1939  
What test confirmed diagnosis? Autopsy Was there an autopsy?

23. If death was due to external cause (violence), fill in the following: Accident, suicide, or homicide. Date of injury 2/10/39

Where did injury occur? 615 29th St (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Home  
Nature of injury Tox. Carbolic Acid

24. Was disease or injury in any way related to occupation of deceased? If so specify None

(Signed) [Signature] M. D.

(Address) [Address]

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**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.**