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.

MAR 9 1939

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

5397
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 596
(c) City Kansas City, Mo. (d) Street No. Research 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.

2. PRINT FULL NAME Mitchell E. Sourdry
(a) Residence, No. Girard, Kansas 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: Fletah Sourdry
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Unknown
7. AGE: YEARS 64 — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Florist
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): Don't Know

FATHER
13. NAME: Don't Know
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

MOTHER
15. MAIDEN NAME: Don't Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

17. INFORMANT (ADDRESS): Research Hosp. Records
18. BURIAL, CREMATION, OR REMOVAL PLACE: Girard, Kansas DATE: 7 13 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): R. V. Lindsey & Sons, 3811 Broadway, K.C. MO.
20. FILED: 7 12 1939 M M Crowe, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): February 11, 1939

22. I HEREBY CERTIFY, That I attended deceased from January 9, 1939, to February 11, 1939
I last saw him alive on February 11, 1938. Death is said to have occurred on the date stated above, at 4:20 p.m.
The principal cause of death and related causes of importance were as follows:

Pulmonary Embolism (Left) (Post operative) — Date of onset

137

Other contributory causes of importance:
Trans Urethr Prostatic Resection Prostate (Benign)
Suprapubic Cystotomy (Calculus)

Name of operation: Prostatic Resection, Suprapubic Cystotomy — Date of: 1/12/39
What test confirmed diagnosis? Lab. — 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: [illegible]
(Signed) 1019 Prof Bldg, M. D.
(Address) K.C. MO

(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 com with the above constitutes grounds for revocation of license.)

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