

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.

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

1939 MAR 9

5456  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395  
 (b) Township Law Primary Registration District No. 1002 Registered No. 655  
 (c) City Kansas City (d) Street No. 2010 Montgall 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. 2010 Montgall 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 Fe 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Underwood  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unk. 1853  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
85 \_\_\_\_\_ \_\_\_\_\_

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home  
 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) Richmond Me.

FATHER 13. NAME Unk.  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk.

MOTHER 15. MAIDEN NAME Mintie Blummond  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unk.

17. INFORMANT (ADDRESS) Dora Hett Taylor  
2010 Montgall

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE 7/15/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hatkins Bros  
1729 Lydia

20. FILED 7/15/39 M. M. Brown  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/15/39

22. I HEREBY CERTIFY, That I attended deceased from Jan 31 1939 to July 15 1939  
 I last saw him alive on July 15 1939 Death is said to have occurred on the date stated above, at 3:10 p.m.

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

Arteriosclerosis  
of heart  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
arteriosclerosis  
of heart

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. M. Brown, M. D.  
 (Address) \_\_\_\_\_

**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. Atkins*

....., or by .....

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

Signed .....

*T. B. Atkins*

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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No..... Registered No. 655  
(c) City..... (d) Street No. 2010 Montgall 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 Nancy Underwood

(a) Residence, No. .... 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

MEDICAL CERTIFICATE OF DEATH

3. SEX ♀ 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 12, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to....., 19....

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

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

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

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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.....

Hemiplegia from cerebral hemorrhage  
87A

Date of onset

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

Other contributory causes of importance:

Ac. Parenchymatous nephritis a complication

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 2/15 1939 M. M. Crowe Local Registrar.

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)....., M. D.

(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCUPATION is very important.

5456