

REC'D MAR 9 1939

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

5514
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. 713
(c) City Kansas City, Mo. (d) Street No. 4020 Brooklyn 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 Elizabeth Bessie Poole
(a) Residence, No. 4020 Brooklyn St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Frank J. Poole
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 14 1872
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 67 — 3
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. At-Home
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) Mo.
13. NAME James Campbell
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. MAIDEN NAME Angelina Collins
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
17. INFORMANT (ADDRESS) W. A. Lohrey
4020 Brooklyn
18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Zion DATE Feb 20 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C.L. Forster
918 Brooklyn Avenue, K.C. Mo.
20. FILED 2719 399 Da. Browne
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17 1939
22. I HEREBY CERTIFY, That I attended deceased from June, 1938, to Feb, 1939
I last saw her alive on Feb 16, 1939. Death is said to have occurred on the date stated above, at 9:30 p.m.
The principal cause of death and related causes of importance were as follows:
Cardiac failure - acute cardiac asthma - chronic fibrotic tuber-culosis
Other contributory causes of importance: 22
anemia
general debility
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? no
If so, specify _____ (Signed) Leora H. Rubnitz, M. D.
(Address) 400 P St 1307
K.C. Mo

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.

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.