

MAR 9 1939

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

5545  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002  
(c) City Kansas City, Mo. (d) Street No. Trinity Lutheran Hospital Registered No. 744  
(If death occurred in Hospital or Institution, write its name instead of street and number) St.  
(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

514 Mrs. Sophie Womboldt  
(a) Residence, No. 2115 West 47th Terrace, Kansas City, 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 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 Pete Womboldt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 17, 1891

7. AGE YEARS 48 MONTHS 0 DAYS 1 If LESS than 1 day, ..... hrs. or ..... min.

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) Russia

FATHER 13. NAME Fred Kinsfather

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

MOTHER 15. MAIDEN NAME Sophie Engelman

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

17. INFORMANT (ADDRESS) Pete Womboldt  
2115 West 47th Terrace

18. BURIAL, CREMATION, OR REMOVAL PLACE Floral Hills DATE Feb. 21, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. V. Lindsey & Sons  
3811 Broadway

20. FILED 720 19 39 M. M. Croome  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1939 to Feb. 18, 1939  
Last saw her alive on Feb. 18, 1939 Death is said to have occurred on the date stated above, at 11:25 PM

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

Generalized Peritonitis Date of onset 2-15-39  
Generalized Peritonitis  
Subovarian abscess & Pelvic peritonitis 1-15-39

Other contributory causes of importance:

Name of operation Expan Date of      
What test confirmed diagnosis? Examine Was there an autopsy? no

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) August H. Lequardt, M.D.  
(Address) 1933 Drury Blvd

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.

187412

Dr. Benjamin W. Johnson  
Proprietor  
2-4

**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.**

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

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1. PLACE OF DEATH (a) County Jackson (b) Township R.C. (c) City (d) Street No. 399 Primary Registration District No. 1002 Registered No. 744 (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. 2115 W-47, Kansas - (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M. 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min. 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 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 17. INFORMANT (ADDRESS) 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19. FUNERAL DIRECTOR (ADDRESS) 20. FILED 2/20, 1939 M. M. Connor Local Registrar.

MEDICAL CERTIFICATE OF DEATH 21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 25, 1939 22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... I last saw him alive on 19... Death is said to have occurred on the date stated above, at... m. The principal cause of death and related causes of importance were as follows: Acute Peritonitis Date of onset 12-16 Other contributory causes of importance: tubo ovarian abscess + pelvic peritonitis (non-puerperal) # probably streptococci Name of operation Date of... What test confirmed diagnosis? Was there an autopsy? No 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 Eugene Ferguson, M. D. (Signed) 933 Prof. Bell (Address)

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTERED ASSISTANTS should state EXACTLY. PHYSICIANS should state

