

REC'D MAR 9 1939

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

5818
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 (d) Street No. 3914 Bell Registered No. 817 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

362 Louise Irene Dieterich
(a) Residence, No. 3914 Bell 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 22, 19 39

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

22. I HEREBY CERTIFY, That I attended deceased from June 1939, 1939, to Feb. 22, 1939. I have seen him alive on Feb. 22, 1939. Death is said to have occurred on the date stated above, at 12:15 P. m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 10, 1853

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 5 12

Myocardial failure
Senility / arteriosclerosis
Date of onset 2/18/39
935

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

Other contributory causes of importance:

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

FATHER 13. NAME Charles Ferris

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

MOTHER 15. MAIDEN NAME Sarah J. Lipe

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT (ADDRESS) Fred C. Dieterich 3914 Bell

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Washington DATE Feb. 24, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gates Funeral Home Kansas City, Kans

20. FILED 7/24 1939 M. M. Brown Local Registrar.

Name of operation No Date of No
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? No
If so, specify
AS (Signed) C. C. Casper, M. D.
(Address) 242 Plaza Medical Bldg
H. C. H.

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.