

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.

31 21 1939 MAR 9 1939

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

5661  
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. 860  
(c) City or Kansas City  
(d) Street No. 3912 Smart 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. 3912 Smart 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 Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 26 1862

7. AGE YEARS 76 MONTHS 3 DAYS 28 If LESS than 1 day, .....hrs. or .....min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
9. Industry or business in which work was done, as saw mill, bank, etc. None  
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) Ohio

FATHER 13. NAME Henry W. Record

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

MOTHER 15. MAIDEN NAME No Record

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

17. INFORMANT (NAME) (ADDRESS) Mrs. Clara Harris  
3912 Smart

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Feb 27 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Foster  
918 Broadway N. C. Mo

20. FILED 7 26 39 M. A. Crowe  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 24 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 6 1939 to Feb 24 1939  
I last saw h. a. alive on Feb 24 1939 Death is said to have occurred on the date stated above, at 2:45 P.M.

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

Carcinoma of Uterus  
48

Other contributory causes of importance:

Name of operation Myeloid Date of no  
What test confirmed diagnosis? Phys findings on 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) M. A. Crowe M. D.  
(Address) 918 Broadway N. C. Mo

*DR. Stephen*  
*William J. ... 1961*  
*Dr. would be in*

**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 conform with the above constitutes grounds for revocation of license.)**

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