

1939 JUN 8

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

17519
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 395
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City, Mo. (d) Street No. 3628 Wyandotte 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 William H. Blood
 (a) Residence, No. 3628 Wyandotte 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Mrs. Constantia H. Blood
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 17th, 1864

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>74</u>	<u>11</u>	<u>19</u>	

OCCUPATION

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

FATHER

13. NAME Stephen H. Blood
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Conn.

MOTHER

15. MAIDEN NAME Jane Knapp
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT Mrs. Constantia H. Blood
 (ADDRESS) 3628 Wyandotte

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE May 8, 1939

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

20. FILED May 8, 1939 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1924, 19... to May 6th, 1939
 I last saw him alive on May 6, 1939 Death is said to have occurred on the date stated above, at 3 a.m.
 The principal cause of death and related causes of importance were as follows:
Myocardial infarction
et chronic degenerative
with myocardial failure
 Date of onset 3 weeks
and 2 years
6 mos.
131

Other contributory causes of importance:
chronic polyneuritis 25 yrs
et nephritis (untreated) 9 years
arthritis
et age

Name of operation None Date of None
 What test confirmed diagnosis? None Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? None Date of injury None, 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 None
 Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? Yes
 If so, specify None
 (Signed) M. M. Brown
 (Address) 612 Chandler Bldg.
1st floor

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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RETURN TO CHIEF OF BUREAU OF HEALTH
COUNTY OF BAYLOR, TEXAS
ROOM NO. 211, DALLAS

Mr. J. J. Darnell
6616134044



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.