

1939 JUN 8 1939

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

17737
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson / Registration District No. 399
 (b) Township Law / Primary Registration District No. 1002 Registered No. 2139
 (c) City Texas city / (d) Street No. Trinity Hospital 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 460 Colijera, Mrs. Cecil Leona St. Kansas City, Mo.
 (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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 25 - 1898

7. AGE YEARS 40 MONTHS 11 DAYS 27 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Secretary
 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) Mo

FATHER 13. NAME Wm Ewing

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Wm

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Mrs. Wella May Polyer
3939 Wyandotte

18. BURIAL, CREMATION, OR REMOVAL PLACE Wm Wash DATE May 25, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rose + Henderson
15 Jackson

20. FILED May 23, 1939 MDM Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1922 to Present, 1939.
 I last saw h. c. r. alive on May 22, 1939 Death is said to have occurred on the date stated above, at 5:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Intestina?
Obstruction
1223

Date of onset 5-21-39

Other contributory causes of importance:
Post-operative Adhesions
of 4 or 5 yrs. duration

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No 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 Yes
 (Signed) Wm E. Owens, M. D.
 (Address) Prof. Bldg
Kansas City

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.

Va - 1403

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.