

33RD JUN 8 1938

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

17757
Do not use this space.

Registered No. 2159

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kan. Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 3014 Forest 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 430 Angelina Field
 (a) Residence, No. 3014 Forest 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 Fe 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25 - 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 9 28

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. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from May 13 1939 to May 24 1939
 I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at 6:30 a.m.
 The principal cause of death and related causes of importance were as follows:
May 13 1939 Date of onset
Intestinal Embolism
11/10

Other contributory causes of importance:
Diarrhea

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

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury no, 19no
 Where did injury occur? no (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. no

Manner of injury no
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. F. Mackey, M. D.
 (Address) Kansas City, Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Jersey

FATHER
 13. NAME John R. Field
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Jersey

MOTHER
 15. MAIDEN NAME Henrietta Ray
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fredon New Jersey

17. INFORMANT (ADDRESS) H. R. Field Ruckers, N.Y.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary N.Y. DATE May 25 1939

19. FUNERAL DIRECTOR (ADDRESS) Clyde Funeral Home

20. FILED May 24 1939 M. M. Grome
 Local Registrar.

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.

I X12004

Mr. [unclear]
2719 Forest Ave 0607

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)