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.

REC'D JUL 10 1939

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

21226
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson 2 Registration District No. 395

(b) Township Kaw 1 Primary Registration District No. 1002 Registered No. 2491

(c) City Kansas City, Mo. (d) Street No. 6010 E. 14th St. 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 Mrs. Malinda Wynn

(a) Residence, No. 6010 E 14th St. 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: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Geo. W. Wynn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Nov. 8, 1861

7. AGE: Years 77 | Months 7 | Days 9 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Homemaker

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): Va

FATHER

13. NAME: Asberry Repass

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Va

MOTHER

15. MAIDEN NAME: Myra Gasse

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Va

17. INFORMANT: John P. Wynn
(ADDRESS) 6010 E 14th St. K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Moriah Cem. DATE June 19-39 19

19. FUNERAL DIRECTOR (NAME) C.H.Blackman & Son, Inc.
(ADDRESS) 2825 Indep. Blvd. K.C.Mo.

20. FILED 6/19, 1939 M. M. Browne
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 17, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from January, 1937, to June 17, 1939, 1939

I last saw her alive on June 16, 1939. Death is said to have occurred on the date stated above, at 9:40 m. AM

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

	Date of onset
Cerebral Hae morrhage	

Other contributory causes of importance:

Nephritis Acute
Exacerbation of a Chronic Nephritis

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an 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) [illegible], M. D.

(Address) 5400 Gladys Ave

(Licensed Embalmer's Statement on Reverse Side)

Dr. Paul Johnson

Indep. & Hardesty

5400 Indep Ave Ch 6/00

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH
(a) County: Jackson
(b) Township: Kaw
(c) City: K. C. Mo
Registration District No.:
Primary Registration District No.: E
Registered No.: 2494
(d) Street No.: 6010 E 14th Street 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: Malinda Wynn
(a) Residence, No. 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: F
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word):
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE: Years 77 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED 6/19 1939 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 17 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	

Other contributory causes of importance:

Acute nephritis	
exacerbation of a chr nephritis	

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an 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? .....
If so, specify .....
(Signed) ....., M. D.
(Address) .....

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

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