

REC'D JUL 10 1939

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

21241

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Raw Primary Registration District No. 109  
(c) City Kansas City (d) Street No. Trinity Lutheran Hosp Registered No. 2509  
(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.  
(If death occurred in Hospital or Institution, write its name instead of street and number)

## 2. PRINT FULL NAME

(a) Residence, No. 420 W. Ora Wells St.  (If nonresident, give city or town and State)  
Chanute Kans  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Oil Driller  
9. Industry or business in which work was done, as saw mill, bank, etc. Oil Driller  
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) Don't know

13. NAME Don't know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Trinity Lutheran Hosp (ADDRESS) Rt. No.

18. BURIAL, CREMATION, OR REMOVAL PLACE Chanute Kans DATE June 22, 1939

19. FUNERAL DIRECTOR (NAME) R. L. Anderson & Sons (ADDRESS) 3411 Bridge St. Chanute

20. FILED 6/20 1939 M. Worson Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-20-39 19

22. I HEREBY CERTIFY, That I attended deceased from 6-10-39, 19, to 6-20-39, 19.

I last saw him alive on 6-10-39, 19. Death is said to have occurred on the date stated above, at 12:55 A.M.

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

Generalized peritonitis Date of onset 6-10-39

Other contributory causes of importance:

acute appendicitis.

Name of operation Appendectomy Date of 6-10-39

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?..... No

If so, specify.....

(Signed) Robert M. Meyer, M. D.

(Address) 1025 Quail Blv

*Embalmer*

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**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.**