

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.

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

21250

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. Children's Mercy Hosp. Registered No. 2518
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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

(a) Residence, No. 3018 Suzanne K. Rude St. Weavenworth, Kansas
 (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 Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-31-39
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin. 0 4 29
 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 -

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

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

MOTHER 15. MAIDEN NAME Vivianne Knight 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Missouri

17. INFORMANT (ADDRESS) Mrs. Vivianne Rude Heavenworth, Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Floral Hills DATE 6-22-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Freeman Mortuary 104 W. 42nd St., K. C., Mo.

20. FILED 6/21 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-20 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-5, 1939, to 6-20, 1939

I last saw her alive on _____, 19____. Death is said to have occurred on the date stated above, at 9:05 p.m.

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

Relational Bronchopneumonia (Pneumonia)
 Other contributory causes of importance: Failure of respiratory

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? _____ 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. S. Sweeney M. D.
 (Address) 1316 1/2 W. 14th St.

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.