DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
EXCHANGE SEP 6 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28288

Registration District No. _____ Primary Registration District No. 399 1002 Registrar's No. 3290

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas city (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: KC Gen Hospt (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days (Specify whether years, months or days)

In this community 41 2 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town Kansas city (If outside city or town limits, write "RURAL")

(d) Street No. 609 W 33 - St (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Alice Dwyer (Viellig)

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced No

6. (b) Name of husband or wife Unk

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July (Month) 30 (Day) 1888 (Year)

8. AGE: Years 51 Months — Days 19 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) MO (State or foreign country)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Charles Cherry
13. Birthplace _____ (City, town, or county) Iowa (State or foreign country)

MOTHER
14. Maiden name Maria Bloom
15. Birthplace _____ (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address KC Gen Hospt

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 21 (Day) 39 (Year)

(c) Place: burial or cremation Forest Hill Cem

18. (a) Signature of funeral director Quirk & Tobin

(b) Address _____

19. (a) Aug. 20, 39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19 year 1939 hour 12 minute 30 A M.

21. I hereby certify that I attended the deceased from July 31 - 1939 19__, to Aug 19 1939 that I last saw her alive on Aug 19-1939; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple Pulmonary Emboli + infarctions with right Empyema

Due to Thrombosis of rt. Varian vein

Due to Chronic Artitis and Chronic Passive Congestion of all organs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 110 A

Of autopsy See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature O. F. De Maria M.D. (M.D. or other)

Address Supt KC Gen Hospt (Date signed)

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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 X19511

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.