

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.

1939 SEP 8

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

29324
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Blair Primary Registration District No. 3019 Registered No. 274
(c) City Independence, Mo. (d) Street No. Independence Sanitarium 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 John Ray French

(a) Residence, 926 E. Walnut Independence, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10, 1901

7. AGE YEARS 38 MONTHS 3 DAYS 20 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Telegraph Operator
9. Industry or business in which work was done, as saw mill, bank, etc. Western Union
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) Missouri

FATHER 13. NAME William H French

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

MOTHER 15. MAIDEN NAME Josie May Akin

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

17. INFORMANT Glenn French (ADDRESS) 3514 Askov, K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Washington Cem DATE Sept. 2, 1939

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

20. FILED 9-2-39 J. A. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 30 1939

22. I HEREBY CERTIFY, That I attended deceased from 8/25/39 19....., 8/30/39 19.....

I last saw decd alive on 8/30 19..... Death is said to have occurred on the date stated above, 8:15 Pm.
The principal cause of death and related causes of importance were as follows:

Gen. Peritonitis, following ruptured extra peritoneal Appendix.

Date of onset

History of sickness 8/21/39

Other contributory causes of importance: 121

Name of operation Drainage Date of 29/39

What test confirmed diagnosis? Was there no autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No 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) [Signature], M. D. (Address) [Address]

W. E. Messenger

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.