

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

31-465
Do not use this space.

OCT 18 1939

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. 4031 Bellefontaine 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 23 yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wallace A. Pike
 (a) Residence, No. 4031 Bellefontaine 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Bertha E. Pike

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12, 1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	73	8	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired R. R.
 9. Industry or business in which work was done, as saw mill, bank, etc. Conductor
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-1-39 to Sept 9, 1939
 I last saw him alive on Sept 9, 1939 Death is said to have occurred on the date stated above, at 2 1/2 m.
 The principal cause of death and related causes of importance were as follows:

Pneumia

Date of onset 8-20-39

Other contributory causes of importance:
Chronic Interstitial Nephritis
Arteriosclerosis 1-1-38

Name of operation None Date of
 What test confirmed diagnosis? Was there an autopsy no

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) G. S. Sheldon, M. D.
 (Address) Gas meter

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York /
 13. NAME Oliver Pike /
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York /
 15. MAIDEN NAME Malisa -
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York
 17. INFORMANT (NAME) Mr. Scott Ambrose
 (ADDRESS) 4031 Bellefontaine
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Forest Hill DATE Sept. 11, 1939
 19. FUNERAL DIRECTOR (NAME) Freeman Mortuary
 (ADDRESS) 104 W. 42nd St., K.C., Mo.
 20. FILED Sept 17th 39 M. M. Crowe
 Local Registrar.

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.

80M-9-19-38
 I X15603

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.....

Clarence W. Chiles

Licensed Embalmer No.....

3473

P. O. Address.....

R. E. M. P.

25
9-30
+
-11
forward

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.