

REC'D OCT 20 1939

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

32623  
Do not use this space.

1. PLACE OF DEATH

(a) County Lapeer Registration District No. 404  
(b) Township Washington Primary Registration District No. 5558 Registered No. 816  
(c) City Kansas City (d) Street No. \_\_\_\_\_ 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 34 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 8005 1/2 south Benton 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Single Lentz (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 14 - 1886  
7. AGE YEARS 53 MONTHS 6 DAYS 14 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
9. Industry or business in which work was done, as saw mill, bank, etc. total years  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/28 1939  
22. I HEREBY CERTIFY that I attended deceased from Sept 14 1939 to Sept 28 1939  
I last saw her alive on Sept 27 1939 Death is said to have occurred on the date stated above, at 3:30 p.m.  
The principal cause of death and related causes of importance were as follows:

Myocardial Regurgitation Date of onset before 1938

Other contributory causes of importance: Hypostatic Pneumonia 9/24/39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Totterville Mo.  
13. NAME William Mc Graw  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know  
15. MAIDEN NAME Caroline Adams  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Moberly Mo.  
17. INFORMANT (ADDRESS) Frank A Brown

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Clinical 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 \_\_\_\_\_

18. BURIAL, CREMATION; OR REMOVAL Lavelock Cemetery DATE Sep. 30 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. R. Rogers  
Hardin  
R. V. Lindsey & Son  
20. FILED \_\_\_\_\_ 19\_\_\_\_  
Sub Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) J. W. Fair M. D.  
(Address) 404 1/2 W 75 1/2

By Koslow H. Licensed Embalmer's Statement on Reverse Side

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.

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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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

32623  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 404  
 (b) Township Washington Primary Registration District No. 5308  
 (c) City..... (d) Street No..... 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 Octavia Anna Lentz  
 (a) Residence, No. .... 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED in

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>53</u>	<u>6</u>	<u>14</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....  
 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).....

FATHER

13. NAME.....  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

MOTHER

15. MAIDEN NAME.....  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY).....

17. INFORMANT (ADDRESS).....

18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE....., 19.....

19. FUNERAL DIRECTOR (ADDRESS).....

20. FILED 11-16-39 1939 Mad. Jos. T. Brennan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/28, 1939

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....  
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.  
 The principal cause of death and related causes of importance were as follows:  
 Date of onset.....

Other contributory causes of importance:

Name of operation..... Date of.....  
 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?.....  
 If so, specify..... (Signed) S. W. Fair, M. D.  
 (Address) 15 E. 78  
404 W 78

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

