

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34989**
Registrar's No. **3964**

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson **NOV 14 1939**
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Waldron
(If outside city or town limits, write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. Betty Ann Adams 352

8. (b) If veteran, name war - No 3. (c) Social Security No. - 710

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Sept. 29, 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name Peter Haase

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Nunn
(City, town, or county) (State or foreign country)

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John B Haase
(b) Address 1001 E. 26th Street

17. (a) Burial (b) Date thereof Oct. 17, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parkville, Missouri

18. (a) Signature of funeral director Freeman Mortuary
(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) 10/16/39 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 14 year 1939 hour 11-5 minute ' P M.

21. I hereby certify that I attended the deceased from Sept to above date of death, 1939 to above date of death, 1939; that I last saw her alive on Oct 14, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage Duration 5 hr

Due to arterial sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy No

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Mary J. Lower (M. D. or other) _____

Address 4176 Walnut Date signed 10-16-39

PHYSICIAN

Underline the cause to which death should be charged statistically.

1-5 PM
41116 W. Belmont
Merrill

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.