

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REG. 2-17-39
REV. 5-1-39

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. **38656**

DEC 1939 399
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. **4420**

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 Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 1/2 days.
(Specify whether in this community Unknown years, months or days)

3. (a) PRINT FULL NAME Claude Biggerstaff
8. (b) If veteran, name war No
8. (c) Social Security No. No

4. Sex M 5. Color or race W.
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive 18 years
7. Birth date of deceased Jan. 11th. (Month) (Day) (Year) 1886

8. AGE:	Years	Months	Days	If less than one day
	53	10	7	hr. min.

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation Drug Store Clerk

11. Industry or business _____
12. Name Thomas J. Biggerstaff
13. Birthplace Missouri
14. Maiden name Euna Wernz
15. Birthplace Minn.

16. (a) Informant's own signature Walter Biggerstaff
(b) Address 3028 Tracy, Kansas City, Mo.

17. (a) Burial (b) Date thereof Nov. 20th
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park,

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn Avenue, K.C. Mo.

19. (a) Nov. 20 1939 (b) M. M. Grown
(Date received local registrar) (Registrar's signature)

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. 1402 Fremont
(If rural, give location)
(e) If foreign born, how long in U. S. A. Unknown years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18
year 1939 hour 1 minute 0 a. m.

21. I hereby certify that I attended the deceased from 6-20
1939 to 11-18, 1939;
that I last saw him alive on 11-18, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Carcinoma of Larynx

Other conditions Broncho-pneumonia
(Include pregnancy within 3 months of death)
Major findings: Terminal
Of operations _____
Of autopsy _____

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? 1 (Specify type of place) (e) Means of injury _____
23. Signature Dr. J. De M... M.D. (M.D. or other)
Address Supr. K.C. Gen Hosp Date signed 11-18-39

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed

C. W. Wise
.....
Licensed Embalmer No. Mo #2570

P. O. Address Kansas City, Mo

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.