

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.

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

38798  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 100  
 (c) City Kansas City (d) Street No. NEUROLOGICAL HOSPITAL St. MO  
 (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 MRS. BESSIE FOUST 230  
 (a) Residence, No. PECULIAR, MO St. MISSOURI  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIFE OF \_\_\_\_\_ (OR) WIFE OF O. U. FOUST

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
56 YRS.

OCCUPATION  
 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.  
 10. Date deceased last worked at this occupation (month and year) 10-14-39 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MISSOURI

FATHER  
 13. NAME Don't know  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

MOTHER  
 15. MAIDEN NAME Don't know  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT HOSPITAL RECORD (ADDRESS) Mo

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Peculiar Mo DATE Dec 2 1939

19. FUNERAL DIRECTOR W. E. Myers (ADDRESS) Cleveland Mo

20. FILED Nov 30 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-29 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-21 1939 to 11-29 1939. I last saw her alive on 11-29-39. Death is said to have occurred on the date stated above, at 11:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
GLIOMA OF BRAIN? Date of onset

Other contributory causes of importance:  
NONE

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 1

24. Was disease or injury in any way related to occupation of deceased? NO  
 If so, specify \_\_\_\_\_ (Signed) Prison Sheltering M. D.  
 (Address) 2625 Paseo Blvd.

55d

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. 2577

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed George Myers

Licensed Embalmer No. \_\_\_\_\_

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

387987  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
(b) Township..... Primary Registration District No..... Registered No. 4562  
(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 Mrs. Bessie Joush

(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 fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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.

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 Nov 20 1939 M. M. Brown  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11 29 - 1939

22. I HEREBY CERTIFY, That I attended deceased from

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:

Stroke of Brain  
n.m.o.  
55 B  
Other contributory causes of importance:

Date of onset

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)....., M. D.

(Address).....

SUPPLEMENTARY

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.

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

