

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9833**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1267**

1. PLACE OF DEATH:

(a) County Kansas  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution  
Trinity Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11/19 Days  
(Specify whether  
In this community 48 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4408 Tracy Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? ----- years.

3. (a) PRINT FULL NAME Mrs. Mary K. Teiperman Ervin

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Lee A. Ervin 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased August 21 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 7 0 hr. ----- min.

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

10. Usual occupation Housewife

11. Industry or business -----

12. Name Louis Teiperman

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

14. Maiden name Louise Anderson

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

16. (a) Informant Lee A. Ervin  
(b) Address 4408 Tracy

17. (a) Removal (b) Date thereof March 23, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hudson - Kansas

18. (a) Signature of funeral director D. N. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) Mar 22 1940 (b) M. M. Browe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21  
year 1940 hour 8 minute 20 a.m.

21. I hereby certify that I attended the deceased from Aug 19 1937 to Mar 21 1940  
that I last saw her alive on Mar 20 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma uterus Duration 2 1/2 yr

Due to Pylephritis Duration 3 wks

Due to Neurologic focal lesions Duration 2 wks

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

Major findings: Of operations -----

Of autopsy none

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) (b) Means of injury -----

23. Signature W. L. Hayes (M. D. or other) !  
Address 1120 Prof. Bldg Date signed 3-21-40

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

MOTHER FATHER

**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..... *A. C. McNewcomer*

Licensed Embalmer No. *4043*

P. O. Address..... *A. C. Mc*

**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.**