

14013

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 1725

57 MAY 15 1940

Registration District No. 399

Primary Registration District No. 1002

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.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas city

(c) Name of hospital or institution: Children's Mercy
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 3 hours
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Delbert B. Clary 460

3. (b) If veteran, name war _____ No. _____

3. (c) Social Security No. _____

4. Sex male

5. Color or race wh.

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 2 - 8 - 37
(Month) (Day) (Year)

8. AGE:

| | | | |
|----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>3</u> | <u>2</u> | <u>15</u> | hr. _____ min. _____ |

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

10. Usual occupation None

11. Industry or business None

MOTHER FATHER

12. Name Elmer Clary

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

14. Maiden name Hazel Anderson

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

16. (a) Informant's own signature Hazel Anderson

(b) Address Stillwell Kansas

17. (a) Removal (b) Date thereof 4-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stillwell, Kans

18. (a) Signature of funeral director Floyd Ruppelius

(b) Address Olathe, Kansas

19. (a) April 23, 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson

(c) City or town Stillwell
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 - day 23
year 1940 hour 5:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 4-23-40 2:00 pm, 1940 to 4-23-40 5:00 pm, 1940;
that I last saw h _____ alive on _____, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumococci Meningitis

Due to _____

Due to _____

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)

(e) Means of injury _____

23. Signature Queller (M. D. or other) _____

Address Home Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.