

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. **1000 JUL 31 1940**

Primary Registration District No. **1002**

Registrar's No. **2484**

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:  
**3823 Genesee Street**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. **40 Years**  
(Specify whether 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. **3823 Genesee Street**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **14th**  
year **1940** hour **11** minute **P.** M.

21. I hereby certify that I attended the deceased from  
**1928** to **June 14**, 19**40**;  
that I last saw him alive on **June 14**, 19**40**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Respiratory Paralysis**  
**cause of death**

Duration

Due to **Pyelonephritis** **81** **2 min**  
Due to **Myelitis** **12 yr**

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **In spinal cord tumor, but**  
**myelitis**  
Of autopsy **Myelitis Pyelonephritis**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 **B. Lambie Evans** (M. D. or other) **M.D.**  
Address **1418 Professional Bldg.** Date signed **6-14-40**

3. (a) PRINT FULL NAME **Dr. Charles Nelson Trask**

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

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

6. (b) Name of husband or wife **Mrs. Anna Trask** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **August 19 1877**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**62 9 26** hr. min.

9. Birthplace **Tremont Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Obstetrician and**

11. Industry or business **Gynecologist**

12. Name **Olin S. Trask**

13. Birthplace **New York**  
(City, town, or county) (State or foreign country)

14. Maiden name **Laura Owen**

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

16. (a) Informant **Ed Trask, Jr.**

(b) Address **504 Walnut**

17. (a) **Cremation** (b) Date thereof **June 17, 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation **D. W. Newcomer's Sons**

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

(b) Address **1401 Brush Creek Blvd.**

19. (a) **June 17, 1940** (b) **M. M. Brown**  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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. 410430

P. O. Address K.C. 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.**