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FILED OCT 11 1940
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31173**
3736
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

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:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **7 days**
(Specify whether)
 In this community **30 yrs**
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 limit, write "RURAL")
 (d) Street No. **1303 Harrison**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Ollie Dyke**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Fred Dyke**
 6. (c) Age of husband or wife if alive **63** years
 7. Birth date of deceased **Jan 19 1881**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	59	8	6	hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Uncle Smith**

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

14. Maiden name **Mo Record**

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

16. (a) Informant **Fred Dyke**

(b) Address **1303 Harrison**

17. (a) **Burial** (b) Date thereof **Sept 27 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn**

18. (a) Signature of funeral director **Wm. C. L. Forster**

(b) Address **918 Brooklyn St. C. Mo**

19. (a) **9-26-40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Sept.** day **25th**
 year **1940** hour **12** minute **55 P.** M.

21. I hereby certify that I attended the deceased from **Sept. 18th**, 19**40**, to **Sept. 25th**, 19**40**;
 that I last saw her alive on **Sept. 25th**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute mycotic aortitis**
 Duration _____

Due to **if/**
 Due to _____

Other conditions **Sarcoma of small intestine**
(Include pregnancy within 3 months of death)

Cerebral embolism

Major findings:
 Of operations _____

Of autopsy **See above**

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? **301**

While at work? _____
(Specify type of place) (by means of injury)

23. Signature **Dancy R. Thom** (M. D. or other) _____

Address **Med. Dir. K. C. Gen. Hospital** Date signed _____

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

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 E. H. Noel

Licensed Embalmer No. 2570

P. O. Address K. E. Moore

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.