

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **37808**

Registration District No. **399**

Emergency Registration District No. **1002**

Registrar's No. **4406**

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 Hosp. #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hours  
(Specify whether  
In this community 22 yrs.  
years, months or days)

3. (a) PRINT FULL NAME ALICEA SUAREZ

3. (b) If veteran, name war None 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 Marciel Suarez 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased Jan. 18 1913  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>27</u>	<u>9</u>	<u>28</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name Jesus Ladero

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

14. Maiden name Antonio Ontarvios

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

16. (a) Informant's own signature Mr. Marciel Suarez

(b) Address 1316 Circle St. K. C. Mo.

17. (a) Burial (b) Date thereof 11 19 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary, K. C. Kan.

18. (a) Signature of funeral director Wailert Funeral Home

(b) Address 2332 Monitor Plaza, K. C. Mo.

19. (a) 11-18-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town 1316 Circle Street  
(If outside city or town limits, write "RURAL")  
Kansas City, Missouri  
(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 \_\_\_\_\_ day 11-16-40  
year \_\_\_\_\_ hour \_\_\_\_\_ minutes \_\_\_\_\_ M.

21. I hereby certify that at the deceased from 9:00 P.  
\_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that last saw alive on \_\_\_\_\_, 19\_\_\_\_;  
and death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Exsanguination  
Incomplete abortion  
Due to \_\_\_\_\_  
Due to (Not Criminal)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Yes

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 means of injury)

23. Signature Wailert (M. D. or other)  
Address K. C. Mo. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

RECORDED  
INDEXED  
DEC 1 1940

WHILE FILLING IN—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.

**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 *Blaine E. Weident*

Licensed Embalmer No. *4075*

P. O. Address *2332 Montou St*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37808

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4406

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town K.C.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Alice Suarez

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 27 Months 9 Days 28 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_ (MEX)  
13. Birthplace (City, town, or county) (State or foreign country) (MEX)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country) (MEX)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) (Date received local registrar) 11/18/40 (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 11 day 16 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Victor B. Buhler (M.D. or other)

Address K.C. Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

