S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13306

FILED MAY 14

Registration District No. 39

Primary Registration District No. 1002

Registrar's No. 1746

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4121 Michigan (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City Mo. Rural 5 (If outside city or town limits, write "RURAL")

(d) Street No.: 88& Indiana (If rural, give location) 8

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country: None

3. (a) PRINT FULL NAME: Matilda M. Engle

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: Single

6. (b) Name of husband or wife: ____

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

7. Birth date of deceased: Nov. (Month) 4 (Day) 1859 (Year)

8. AGE: Years 82 Months 5 Days 27 If less than one day ____ hr. ____ min.

9. Birthplace: Louisana (City, town, or county) 1 (State or foreign country)

10. Usual occupation: None

11. Industry or business: None

MOTHER FATHER

12. Name: Henry Engle 4

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

14. Maiden name: Elizabeth Kelsch

15. Birthplace: Germany 4 (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Kiekbush

(b) Address: 4121 Michigan

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5/4/42 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park (Mo.)

18. (a) Signature of funeral director: Harlyn Roe

(b) Address: 7406 Wordall Rd.

19. (a) May 4 1942 (Date received local registrar) (b) M. B. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 1st year: 1942 hour: 3 P.M. minute: ____ M.

21. I hereby certify that I attended the deceased from May 1 1942, to May 1 1942, that I last saw her alive on May 1 1942. and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchio-pneumonia	24 hours.
Due to: arterio-sclerosis	3 years
Due to: 107	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: none performed.	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: James Middleton (M.D. or other) M.D.

Address: 926 North Montgall Date signed: 5-8-42

361 (Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.