

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

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

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:  
St. Joseph Hospital, I  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 3-25-43  
(Specify whether years, months or days)

In this community Since March 25th, 1943, (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town Malta Bend,  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Delia Spiers,

3. (b) If veteran, name war no. 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 Lloyd W. 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 11, 1894  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

49 1 8 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name Sales Henry Kiser

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

14. Maiden name Patay A. Manning

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

16. (a) Informant Sales H. Kiser

(b) Address Malta Bend, Mo.

17. (a) Removal (b) Date thereof 4-19-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Missouri

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 4-19-43 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th  
year 1943 hour 5:20 minute \_\_\_\_\_ a. \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan 1943 to April 19, 1943; that I last saw her alive on April 19, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death post operative shock, 2 hrs  
Duration \_\_\_\_\_

Due to Resection of Colon for Carcinoma of Colon  
Due to of Colon 4 1/2 year

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

Major findings: Carcinoma of Sigmoid Colon  
Of operations \_\_\_\_\_  
Of autopsy Same

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) (e) Means of injury \_\_\_\_\_

23. Signature W. B. Blanchard MD (M.D. or other) 4-19-43  
Address 715 Doyle, Aldy K. Pao Date signed \_\_\_\_\_

Dr. M. B. Casebolt

W.S. & Disackway

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 E. M. Plausky  
Licensed Embalmer No. 1848  
P. O. Address T. C. Mc

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.