

FILED NOV 1 1943

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH: Jackson
 (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: Kansas City Convalescent Home 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 1 Month
 In this community: Unknown (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Jackson 48
 (c) City or town: Kansas City 3
 (If outside city or town limits, write "RURAL")
 (d) Street No.: 3200 Norledge 8
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country: 0

3. (a) PRINT FULL NAME: Bella Van Antwerp
 3. (b) If veteran, name war: No.
 3. (c) Social Security No.:

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 5
 year 1943 hour 6 minute 0 M.
 21. I hereby certify that I attended the deceased from 8-13-43
 19 to 10-5-43 19
 that I last saw her alive on 10-5-43 19
 and that death occurred on the date and hour stated above.

4. Sex: F 5. Color or race: W
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife:
 6. (c) Age of husband or wife if alive: years

Immediate cause of death:
 Due to: Atherosclerosis
 Due to: 97
 Other conditions: (Include pregnancy within 3 months of death)
 Major findings:
 Of operations:
 Of autopsy:

7. Birth date of deceased: (Month) (Day) (Year)
 8. AGE: 76 Years Months Days If less than one day hr. min.

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

10. Usual occupation:

11. Industry or business:

MOTHER FATHER }
 12. Name: 9
 13. Birthplace: (City, town, or county) (State or foreign country) 9
 14. Maiden name:
 15. Birthplace: (City, town, or county) (State or foreign country) 9

16. (a) Informant:
 (b) Address:

17. (a) Removal (b) Date thereof: 10/8/43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Brookfield, Mo.

18. (a) Signature of funeral director: Melody - McGilley
 (b) Address: K. G. Mo.

19. (a) 10-8-43 (b) D. E. Brown
 (Date received local registrar) (Registrar's signature)

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: (M. D. or other) 10-6-43
 Address: Date signed:

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Russell H France
Licensed Embalmer No. 2255
P. O. Address H O 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4294

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town H. C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
H. C. Conv. Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo
(Specify whether years, months or days) 00 yrs

3. (a) PRINT FULL NAME Belle Van Antwerp

3. (b) If veteran, name war no 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Eugene J. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 8 (Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 27 If less than one day min.

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

10. Usual occupation invalid

11. Industry or business

12. Name William Wallace Wyman

13. Birthplace Checkersburg (City, town, or county) W. Va. (State or foreign country)

14. Maiden name Alma Dogg

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

16. (a) Informant Lee E. Wyman

(b) Address 21 S. Western, Okla. City Okla.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-8-43 (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Mo.

18. (a) Signature of funeral director Melody Mc Gilly

(b) Address H. C. Mo.

19. (a) 10-8-43 (Date received local registrar) (b) P. C. 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. 3240 Northledge
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 19 Year 1943
hour minute M.

21. I hereby certify that I attended the deceased from 19.....
that I met 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.....

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work?..... (Specify type of place)
(c) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

MOTHER FATHER

SUPPLEMENTARY

331092