S. No. 2
OM—2-43
5-17-39
X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

33447

State File No. 4158

FILED OCT 29 1944

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson Co.
(b) City or town K.C. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Osteopathic Hospital. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Caldwell 13
(c) City or town Polo 0
(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 1

3. (a) PRINT FULL NAME Lillian Studer

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fem

5. Color or race wh

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband ~~or wife~~ P. P. Studer

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

7. Birth date of deceased May (Month) 1 (Day) 1911 (Year)

8. AGE:

Years	Months	Days	If less than one day
33	5	14	hr. min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation

11. Industry or business

FATHER
12. Name Wm T. Missey
13. Birthplace Crawford Co. (City, town, or county) Mo (State or foreign country) 0

MOTHER
14. Maiden name Martha E Dicus
15. Birthplace Crawford Co (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant Mrs Martha Cox
(b) Address Polo Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 17 (Day) 44 (Year)
(c) Place: burial or cremation Lathrop Mo

18. (a) Signature of funeral director Alspaugh & Cowley
(b) Address Polo Mo

19. (a) 10-15-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15
year 1944 hour 11 minute 06 P.M.

21. I hereby certify that I attended the deceased from Oct. 14, 1944, to Oct 15, 1944, that I last saw h. E.R. alive on Oct 15, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia & Shock adhesions - previous operation (NMO)

Due to Mechanical obstruction of bowel from Oct 11 to Oct 14 '44

Due to Toxemia & shock & operation for release of obstruction

Other conditions (Include pregnancy within 3 months of death) 122 b

Major findings:
Of operations Obstructed & Gangrenous bowel
Of autopsy

Duration

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 A. E. Linville (M. D. or other) D.O.
Address Osteopathic Hospital - K.C., Mo. Date signed 10/16/44

(Licensed Embalmer's Statement on Reverse Side)

OCT 19 1966

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.

. S. No. 2B
0M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. N02

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4158

1. PLACE OF DEATH:

(a) County Jackson Co

(b) City or town Kansas city
(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)

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lillian Studer

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 May (Month) 1 (Day) 1951 (Year)

8. AGE: Years 33 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

10. Usual occupation Home

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

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) (b) F E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15
year 1944 hour minute M.

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

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

33447