

No. 2
 1-5-43
 5-17-39
 I X36671

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

FILED AUG 19 1947
 749

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

27582
 State File No. _____
 Registrar's No. 3308

Registration District No. _____

Primary Registration District No. 1002

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. Luke's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 weeks
47 years (Specify whether years, months or days)
 In this community _____

3. (a) PRINT FULL NAME Otto G. Bernard
 3. (b) If veteran, name war no.
 3. (c) Social Security No. no.

4. Sex male
 5. Color or race white
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mrs. Ida Bernard
 6. (c) Age of husband or wife if alive unknown years
 7. Birth date of deceased September 9 1881
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 10 25 24 hr. min.

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

10. Usual occupation Furniture Dealer

11. Industry or business X

MOTHER FATHER { 12. Name Benjamin Bernard
 13. Birthplace unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Coyle
 15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Otto G. Bernard

(b) Address 3338 Karnes Blvd., Kansas City, Mo.

17. (a) burial (b) Date thereof 8 - 6 - 47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

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

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

19. (a) 8-5-47 (b) Geraldine Holmes
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3338 Karnes Boulevard,
 (If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 7-1 to 8-3-47
 and that death occurred on the date and hour stated above.
 Immediate cause of death: Metastatic Ca. Liver
 Duration 6 mths

Due to Ca - Recto-Sigmoid
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: 462
 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?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature J. V. Well (M. D. or opt.)
 Address 132 Professional Bldg Date signed 8-5-47

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

178 MO

C. H. Bell

Dr. J. V. Bell

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..... *Robert H Reed*.....
Licensed Embalmer No..... *3745*.....
P. O. Address..... *112 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.