

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32277

399

4258

1. PLACE OF DEATH

County Jackson Registration District No. 1002 File No. 4258
Township 1st Precinct Registration District No. 14th Registered No. _____
City Kansas City No. _____ St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 439 Dr 14th St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE/MARRIED, WIDOWED OR DIVORCED (write in forward) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>About</u>	<u>if</u>			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kansas City Missouri

10. NAME OF FATHER

John Sallas

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

12. MAIDEN NAME OF MOTHER

J. Provost

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

14.

INFORMANT John Sallas
(Address) 439 Dr 14th

15.

FILED 12/5 19 21 7 27 m. Crocuel
REGISTRAR By

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 5th 1921

17. I HEREBY CERTIFY, That I attended deceased from December 5th 1921, to December 8th 1921 that I last saw her alive on Dec 5th 1921 and that death occurred, on the date stated above, at 1130 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pharyngeal Diphtheria

CONTRIBUTORY Name (SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: Do not know

DID AN OPERATION PRECEDE DEATH: No. DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DIAGNOSIS: Name

(Signed) A. M. Goldman, M. D.

15, 19 21 (Address) 736 Lee Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys DATE OF BURIAL 12/6/21

20. UNDERTAKER F. O'Donnell Co ADDRESS 1109 Broadway

WRITE CAREFULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

W. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

