

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

Do not use this space.

15021

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township KSW Primary Registration District No. 1002
 City Kansas City (No. 2650) Victor St. _____ Ward _____

File No. _____
 Registered No. 1328

2. FULL NAME

Marguerite Calnan

(a) Residence. No. 2650 Victor 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. P. Calnan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 23rd 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
33

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ornogo
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Dr. Wm. Myers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not Known
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Miss Howell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known
 (STATE OR COUNTRY) Illinois

14. INFORMANT J. P. Calnan
 (Address) 2650 Victor

15. May 9, 1927 M. M. Brown
 REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927 to May 8, 1927 that I last saw him alive on May 27, 1927, and that death occurred, on the date stated above, at _____ a. m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Lungs
interst

CONTRIBUTORY (SECONDARY) 46
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____

WAS THERE AN AUTOPSY, _____

WHAT TEST CONFIRMED DIAGNOSIS.
 (Signed) W. L. Ray, M. D.

5-9-1927 (Address) 321 Altman

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 5/10 1927

20. UNDERTAKER The Taylor Funeral Home Inc
 ADDRESS _____

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

M. 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.

RECEIVED
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WASHINGTON, D.C. 20330

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
 Township..... Primary Registration District No. 1002 Registered No. 1888
 City Kans. City St. Ward)

2. FULL NAME

(a) Residence. No. 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 D. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M.
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 23 - 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
32 6 15 1/2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 5/9, 27 M. M. Brown REGISTRAR
ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1927

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.
 , 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

WRITE PL. INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-15021