

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

Do not use this space.

36777

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 4593  
 Township Trass Primary Registration District No. 1002 Registered No. 4593  
 City K.C. Mo. (No. 5911 Lexington av.) St.                      Ward                     

**2. FULL NAME**

John H. Cadden  
 (a) Residence No. 5911 Lexington St. Ward                       
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 10 da.                      How long in U.S., if of foreign birth? yrs. mos. da.                     

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (WIFE) OF Anna

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June-4-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 | 5 | 29 |                     

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Retired U.P.  
 (b) General nature of industry, business, or establishment in which employed (or employer) Engineer  
 (c) Name of employer                     

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peoria

10. NAME OF FATHER Quinn Cadden

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

12. MAIDEN NAME OF MOTHER Miss Harley

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

14. INFORMANT Anna Cadden  
 (Address) 5911 Lexington

15. FILED 12/5/27 9m.m.                      REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec-3-1927

17. I HEREBY CERTIFY, That I attended deceased from 15 1927, to Dec 3, 1927  
 that I last saw                      alive on Dec 3, 1927 and that death occurred, on the date stated above, at 4:45 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
M.M.O.C. arthritis chronic  
(Chronic nephritis) 131

abt (duration) 21 yrs. mos. da.

CONTRIBUTORY nephritis; chronic  
 (SECONDARY) (duration)                      yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH, no DATE OF                       
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS                       
 (Signed) K.P. Jones M. D.  
3/4, 1927 (Address) 422 E 11<sup>th</sup> St.

\*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 Dec-6-1927

20. UNDERTAKER                      ADDRESS                       
Mrs. C. L. Foster K.C. Mo.

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

N. 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.

1100 / 1000000  
4218 11st.