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.

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

Do not use this space. 17016

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 1980
Township — Primary Registration District No. 1002 — Registered No.
City Kansas City (No. St Josephs Hosp St. Ward)

2. FULL NAME C R Earlywine
(a) Residence. No. Bosworth Mo St., Ward. Bosworth Mo.
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 28 1876

7. AGE: Years 51 — Months 7 — Days 3 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): Carroll Co

PARENTS
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: Mrs Cora Earlywine
(Address) Bosworth Mo

15. FILED 5/3, 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

5

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-1 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1928, to May 1", 1928, that I last saw him alive on May 1", 1928, and that death occurred, on the date stated above, at 2 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Emphysema - Right Pleura
anterior - Mediastinitis
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Sub Phrenic abscess following Cholecystectomy (duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? yes DATE OF April 25"
WAS THERE AN AUTOPSY? yes -
WHAT TEST CONFIRMED DIAGNOSIS? autopsy -
(Signed) F. C. Lamar, M. D
5/2, 1928 (Address) 915 Argyle 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Carrollton Mo — DATE OF BURIAL: 5/3 1928

20. UNDERTAKER: Willis Bros — ADDRESS: Carrollton Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Accuracy 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.

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.:
Township: — Primary Registration District No.: 1087 — Registered No.: 1980
City: K. City (No. ..., St. ..., Ward)

2. FULL NAME: C. A. Earlywine

(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
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 5/3, 1928 M. M. Lenowe Registrar
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 - 1928

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 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:
Empyema - right pleura
Anterior - mediastinitis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Sub phrenic abscess
following Cholecystectomy (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH?
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D
(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.

SUPPLEMENTARY 1243

Gall bladder was removed for chronic cholecystitis. The collection of fluid under the diaphragm was neither pus or urinous - simply a serous exudate. Patient died following a spinal injection - Novocain.

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

20. UNDERTAKER — ADDRESS

910L1-5