

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

Do not use this space.

17398

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 2074
 Township Beau Primary Registration District No. 1002 Registered No. 5 2074
 City Kansas City (No. 7 C. General Hospital St. Ward)

2. FULL NAME

(a) Residence No. 2087 Space 12
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 52 yrs. mos. 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 (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7 - 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
47 50 10 22

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Cass City
 (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER B. Malone

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

12. MAIDEN NAME OF MOTHER Mary McLean

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

14.

INFORMANT Re. waller
 (Address) 7 C General Hosp.

15.

FILED 3/30, 1928 M. M. Coe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-29 1928

I HEREBY CERTIFY, That I attended deceased from 5-17, 1928, to 5-29, 1928 that I last saw him alive on 5-29, 1928, and that death occurred, on the date stated above, at 3:45 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:**

Acute hepatitis - Chronic Myocarditis - Chronic Endocarditis

CONTRIBUTORY Broncho-pneumonia
 (SECONDARY)

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? Plen findings

(Signed) P. E. Williams, M. D.
5-24, 1928 (Address) Dept 7 C Genl Hosp

*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

St. Marys 5-31 1928

20. UNDERTAKER

ADDRESS

O. V. West

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

STATE OF TEXAS
COUNTY OF DALLAS

NOTARIAL PUBLIC
My Comm. Expires

NOTARIAL PUBLIC
My Comm. Expires

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 Jackson
 Township St. City
 City St. City (No. St. Ward)

Registration District No. 399
 Primary Registration District No. 1002

File No.
 Registered No. 2371

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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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)

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 9/30, 1928 M. M. Browne REGISTRAR
Acser

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-29-28

17. I HEREBY CERTIFY That I attended deceased from 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

19

20. UNDERTAKER

ADDRESS

K676

RECORD

3 IS A

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

SUPPLEMENTARY

5-17398