

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

Do not use this space.

1485

1521

1. PLACE OF DEATH

County Jackson
Township Raw
City St. C. Mo. (No. Wesley Hospital)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Walter Frederick Kinnaman
(a) Residence. No. Peculiar, Mo. St. _____ Ward _____
(Usual place of abode)

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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie Corning Kinnaman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 10 - 1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
36 11 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Trucking
(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) Mo.

10. NAME OF FATHER

Ben Kinnaman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER

Jessie Penn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Iowa

14.

INFORMANT Nellie Corning Kinnaman
(Address) Peculiar, Mo.

15.

FILED 5. 29 McDermott
Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 - 1929

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental Automobile
Traumatism Cause
2:10 PM

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? History, Physical

(Signed) Sherry M. Black, M. D.

1/5, 1928 (Address) Asst. Coroner

*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

Lee Summit Jan - 7 - 1929

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster K. C. Mo.

RECORD - THIS IS A VITAL RECORD

fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state to that it may be properly classified. Exact statement of OCCUPATION is very important.

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9

104

1
2

[illegible]

**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.....
Township.....
City.....

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 52
St. Ward)

2. FULL NAME

Walter Frederick Kinsman

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

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)

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 15 29 m. m. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1929

17. I HEREBY CERTIFY, That I attended deceased from to
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:

Deep fatal Automobile
Tramway Collision
Near Butler Mo
(duration) mos. da.

CONTRIBUTORY
(SECONDARY)

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

19

WRITE PLAINLY, WITH UNFADING INK. THIS IS A FREE SERVICE. PHYSICIANS should state EXACTLY. 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-1465