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

Do not use this space.

1536

48
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9

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.: 127

Township: Kan — Primary Registration District No.: 1002 — Registered No.:

City: K. C. Mo. (No. Old City Hospital St. Ward)

last name

2. FULL NAME Dale, Thomas

(a) Residence. No. 2425 Flora Ave St., 4 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ~~56~~ mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	Colored	Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ella Dale. ?

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12, 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
52	—	6	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labour

(b) General nature of industry, business, or establishment in which employed (or employer): Comon Labor.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER: Dale, Geo.

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

12. MAIDEN NAME OF MOTHER: Elliott, Sarah

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

14. INFORMANT: Mrs. Caldwell
(Address) 2425 Flora Ave

15. FILED Jan 11, 1929 M. M. Crowe Asst REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-8-1929

17. I HEREBY CERTIFY, That I attended deceased from 12-29, 1929, to 1-8-, 1929 that I last saw him alive on 1-8-, 1929, and that death occurred, on the date stated above, at 2:10 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac failure
(Acute dilatation)
[illegible]
[illegible] (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Pulmonary Abscess
recent Pulmonary Tuberculosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory
(Signed) Harvard M. Smith, M. D
1/9, 1929 (Address) Old City Hospital.

*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
Highland Cem.	Jan 12 1929
20. UNDERTAKER	**ADDRESS**
Adkins Bros.	2000 E. 12 St.

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.