

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.

1903

1. PLACE OF DEATH

County Jackson

Registration District No. 399

File No.

Township Kaw

Primary Registration District No. 1002

Registered No. 496

City Kansas City

No. 12 th & Cleveland on R.R. Tracks

St.

Ward

2. FULL NAME William Bernard Malia

(a) Residence. No. 1827 Jefferson St.

3 Ward.

(If nonresident give city or town and State)

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

Fern Malia

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 30th 1898

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

30

5

0

8. OCCUPATION OF DECEASED

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

Switchman

(b) General nature of industry, business, or establishment in which employed (or employer)

K.C. Termanil R.R.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

PARENTS

10. NAME OF FATHER

Bryan Malia

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER Ella Wright

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT (Address)

Mrs Fern Malia
1827 Jefferson

15.

FILED

1-31-29
M. W. Gove
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1929

17.

I HEREBY CERTIFY, That I attended deceased from

, 19

, to

, 19

that I last saw him alive on , 19 , and that death occurred, on the date stated above, at .m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental R.R.
Exhaustion
2096

(duration)

yrs.

mos.

da.

CONTRIBUTORY (SECONDARY)

Pan over by train

(duration)

yrs.

mos.

da.

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)

Inspector
Shawley in Hall M. D.

1/31

1929

(Address) Deputy 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

Hannibal Mo.

DATE OF BURIAL

1/31/29 19

20. UNDERTAKER

R.V. LINDSEY & SONS Inc.

ADDRESS

K City, Mo

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City.....*K. City*.....

Registration District No. *399*
Primary Registration District No. *1002*

File No.
Registered No. *496*
St. Ward.....

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) *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 *1/21* 19*29* *M. M. Crowley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 31* 19*29*

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:

accidental R. R. traumatism
No automobile involvement
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Ran over by train*
(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) *Stanley Hare*, 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

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

S-1903