2,00

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

Do not use this space.

6417

File No. 5626

Registered No. 700

399

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1. PLACE OF DEATH

County Jackson — Registration District No.

Township Kaw — Primary Registration District No.

City Kansas Cities (No. Kansas City Genl Hosp. St. ... Ward)

2. FULL NAME Dale Oliver

(a) Residence. No. 3618 Wilson 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ... min.
	74			

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

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Record Clerk
(Address) Kansas City Genl Hosp

15. FILED 2-5 1929 M M Lowe Asst REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-24, 1929, to 2-4, 1929 that I last saw him alive on 2-4, 1929, and that death occurred, on the date stated above, at 8:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(Hemiplegia)
... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia
... (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) T. E. Wellemeier, M. D
2-5, 1929 (Address) Supt K.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 Brookings Cem — DATE OF BURIAL Feb 7 1929

20. UNDERTAKER A. P. Doehler — ADDRESS 1415 E 15

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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

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