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

Do not use this space.
10914
10864
1425

File No. .....
Registered No. .....

1. PLACE OF DEATH
County Jackson
Township ..... Registration District No. .....
City Kansas City Mo (No. St Anthony Home St. ..... Ward)
Primary Registration District No. .....

2. FULL NAME James Arnold
(a) Residence. No. 2300 College 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. 17 ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 4-1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			17	

8. OCCUPATION OF DEceased
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

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

PARENTS

10. NAME OF FATHER Richard Welch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Des Moines
(STATE OR COUNTRY) Iowa
12. MAIDEN NAME OF MOTHER Eva Rodger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Chicago
(STATE OR COUNTRY) Ill

14. INFORMANT Eva Rodger
(Address) 2300 College

15. FILED ..... 19..... Jn M Crow
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/21/29 19

17. I HEREBY CERTIFY, That I attended deceased from 3/4 19 29 to 3/21/29 19, that I last saw h. alive on 3/21/29 19, and that death occurred, on the date stated above, at 8 45 a m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Bronchopneumonia
(Primary)
Total
(duration) ..... yrs. 3 mos. ..... ds.
CONTRIBUTORY (SECONDARY) None
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? yes
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Sys
(Signed) J. H. Miller, M. D
3/22 19 (Address) 915 Argyle

*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: St Marys-Com
DATE OF BURIAL: Mar 23 1929

20. UNDERTAKER: John W Wagner
ADDRESS: 1409 Grand Ave

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.

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