

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Isaiah
City Kansas City, Mo. (No. 1858 East 68th Terr)

Registration District No. 399
Primary Registration District No. 1002

File No. 18110
Registered No. 2155
St. _____ Ward _____

2. FULL NAME

Delos M. Harkin
(a) Residence, No. 1858 East 68th Terr., 15 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 8 mos. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 13 - 1871

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
58 2 27

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) carpentry
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ind
10. NAME OF FATHER A. S. Harkin

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

12. MAIDEN NAME OF MOTHER Miss Woodbury

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not known

14. INFORMANT Laura Belle Harkin
(Address) 1858 East 68th Terr

15. FILED 5/10, 1929 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1929

17. I HEREBY CERTIFY, That I attended deceased on April 25, 1929 that I last saw him alive on April 25, 1929, and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Creeping paralysis -

CONTRIBUTORY (SECONDARY) 73 (duration) 1 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Chas. Sherman M. D.

(Address) 5-10, 1929 4707 Froosh

*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. Louis, Mo. DATE OF BURIAL May 11 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.

RECORD WITH ORIGINAL IN THIS IS A PERMANENT RECORD

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