

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

Do not use this space.

21349

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township Blue Primary Registration District No. 3019
 City Independence Mo. (No. Independence Sanitarium St. _____ Ward)

File No. _____
 Registered No. 229

2. FULL NAME

(a) Residence. No. 2235 Archerway 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. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write last word) wid
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Blanton
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 28 1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 5 15

8. OCCUPATION OF DECEASED

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

Kansas
James Smith
Kansas
Ruth Knowles
Kansas
Mrs A. R. Hedrick
623 E. 26 St
6-13, 1929 F L Cook
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13 1929
 17. I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 13, 1929, that I last saw h. alive on June 12, 1929, and that death occurred, on the date stated above, at 9:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronch. Pneumonia
92A
107A
 (duration) yrs. mos. 3 ds.
 CONTRIBUTORY Valvular Heart Disease (SECONDARY)
 (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) J. E. Hakenes, M. D.

June 13 1929 (Address) Independence Mo

*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

Troy Kansas 6-14 1929
 20. UNDERTAKER Mrs C L Foster K C Mo.
 ADDRESS

N. B. - If any 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.

Hope in

signed by

1263.

Dr. H. C. ...
 21-5
 in ...
 ...
 ...
 ...

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Indep.
City Indep. (No. St. Ward)

Registration District No. 398
Primary Registration District No. 3019

File No.
Registered No. 229

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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 28-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 8 5 137

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(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 8/17 1929 F. L. Coon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13 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:

CONTRIBUTORY (SECONDARY)

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) 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

PHYSICIANS should state EXACTLY. EXACT STATEMENT OF CAUSE OF DEATH is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA. 1

SUPPLEMENTARY

S-21349