

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

Do not use this space.

21513
2649

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kansas City Primary Registration District No. 1002
 City Kansas City (No. St. Joseph Hospital)
 Registered No. _____ St. _____ Ward)
 2. FULL NAME Clyde McPherson
 (a) Residence. No. 3540 Paseo St. 13 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frances McPherson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-1st, 1902
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
26 9 11

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. File Letter
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Indp. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER J.C. McPherson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Mrs. E. Reary
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kans
 (STATE OR COUNTRY)

14. INFORMANT Frances McPherson
 (Address) 3540 Paseo

15. FILED 6/13/29 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) June-12 1929
 17. I HEREBY CERTIFY, That I attended deceased from 5-15-29
 _____, 19____, to 6-12 _____, 19____.
 that I last saw him alive on 6-12 _____, 19____, and that death occurred, on the date stated above, at 9:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocardial Failure
114A
193D

(duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Lung abscess & Non Tubercular
 (duration) yrs. mos. ds. 8 weeks

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 Examination
 (Signed) George F. Fisher M. D.
6-13-1929 (Address) 336 Sathrop

*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. Washington DATE OF BURIAL 6/14/1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS R.P. 240

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

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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325 W.S. Receipt-
Kathryn Berg
vic 7010

12,700.00 130 Friday

Jan 4343