

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

Do not use this space.

21722

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Law

Primary Registration District No. 1002

City Kansas City, Mo.

No. 2929 Main

File No. 2862

Registered No. _____

St. Willow

2. FULL NAME

Claude Marshall

(a) Residence. No. 2929 Main St. Willow

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 8 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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 20, 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. — 1 9

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work teacher (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) Bonner Springs Kansas

10. NAME OF FATHER unk

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

12. MAIDEN NAME OF MOTHER Elicia Lena Marshall

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

14. INFORMANT All Kansasy R. N. (Address) 2929 Main

15. FILED 6/30/29 M. M. Crouse REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 1929

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to June 29, 1929. that I last saw h.l.m. alive on June 28, 1929, and that death occurred, on the date stated above, at 1:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

189 189 Prematurity (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Malnutrition (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? None (Signed) H. H. Dwyer M.D.

(Address) 74 Medical Arts Bldg

*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 Maple Hill DATE OF BURIAL July 10 1929

20. UNDERTAKER Eglar Funeral Home ADDRESS 1600 Linwood

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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