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

Do not use this space.
24649
3061

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

1. PLACE OF DEATH

County Jackson — Registration District No. .....
Township Kaw — Primary Registration District No. .....
City Kansas City (No. General Hospital St. ..... Ward)

2. FULL NAME James Edgar Todd

(a) Residence. No. 3441 Summit St., 5 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 26 1896

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	9	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Foreman-KC. Stock Yards
(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) Missouri

PARENTS
10. NAME OF FATHER James H Todd
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Mary Coccoran
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

14. INFORMANT James H. Todd
(Address) 3441 Summit

15. FILED 7-12 19 29 M. M. Crane asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/12 1929

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner
..... 19..., to ..... 19...
that I last saw h..... alive on ..... 19..., and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Homicide by Stab wound of liver.
1 pt
(duration) ? yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Stanley McHall, M. D
7-12, 19 29 (Address) Deputy Coroner

*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 Calvary Cemetery — DATE OF BURIAL 7/15/29 19

20. UNDERTAKER Quirk & Tobin Co--20 W Linwood — ADDRESS

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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