

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

Do not use this space.

3077
24665

1. PLACE OF DEATH

County..... *Jackson*
Township..... *Jackson*
City..... *Kansas City*

Registration District No. *1002*
Primary Registration District No.
(No. *General Hospital*)

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence, No. *566 Tracy* St., *1* 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

W

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)

June 7, 1927

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>2</i>	<i>1</i>	<i>7</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... *None*
(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) *Chicago Illinois*

PARENTS

10. NAME OF FATHER *John De Mayo*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Pueblo Colorado*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Oleta Swing*

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

14.

INFORMANT *John De Mayo*
(Address) *566 Tracy*

15.

FILED *7/15-29 M. M. Crowe*
19. *asst. REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7/14 1929*

17. I HEREBY CERTIFY, that I attended deceased from *July 14*, 19*29*, to *July 14*, 19*29*, that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

meningitis Epidemic

CONTRIBUTORY (SECONDARY)

24

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS *Autopsy*

(Signed) *Stanley M. Dale*, M. D.

7/15, 1929 (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

Mt. St. Mary's

DATE OF BURIAL

July 16 1929

20. UNDERTAKER

A. Sebbeto

ADDRESS

Kc City, Mo

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.

