

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

Do not use this space.

27763

3453

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Town Law Primary Registration District No. 1002
 City Kansas City (No. 564 Cottage Lane)

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Manuel Ward _____

(a) Residence. No. 564 Cottage Lane Ward _____ (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 Ma 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9, 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
41 3 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Tenn.

10. NAME OF FATHER Joe Delcher

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

12. MAIDEN NAME OF MOTHER Annie

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

14. INFORMANT Samuel Ruth

(Address) 564 Cottage Lane

15. FILED 8/12/29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/9/29

17. I HEREBY CERTIFY. That I attended deceased from Aug. 2, 1929 to Aug. 9, 1929 that I last saw her alive on Aug. 9, 1929 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Pleurisy with Effusion & Empyema

CONTRIBUTORY (SECONDARY) acute capillary Bronchitis
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Don't know
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) Chas. E. Briscoe M. D.
8/12/29 (Address) 811 Euclid Ave

*State the DISEASE CAUSING DEATH, or in death 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 8/12/29

2. UNDERTAKER Hutchins Bros ADDRESS 1729 Cydon

WRITE PAINLY, 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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G. E. Briscoe, 811 Indep. Ave.