

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

Do not use this space.

30918

3942

**1. PLACE OF DEATH**

County Jackson  
Township Franklin  
City Research City (No. Research Dist 2)

Registration District No. 399  
Primary Registration District No. 2

File No. 3942  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Jacqueline Whiteman Carbaugh

(a) Residence No. 1234 Huntington Rd 8 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 Fe. 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) Feb. 2 - 1924

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
5 7 16

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Primary Dept  
(b) General nature of industry, business, or establishment in which employed (or employer) School  
(c) Name of employer 63 Wornall Rd

9. BIRTHPLACE (CITY OR TOWN) Kansas City  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Glenn C. Carbaugh

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

12. MAIDEN NAME OF MOTHER Faye Whiteman

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

14. INFORMANT Dr. Eugene Carbaugh  
(Address) 7720 Wornall

15. FILED 9/20 29 M. M. Ernie REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 18 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Sept 18, 1929 that I last saw him alive on Sept 18, 1929 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Ac. Osteomyelitis 154  
Acute Acidosis 36  
\_\_\_\_\_ 6913  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. 2 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

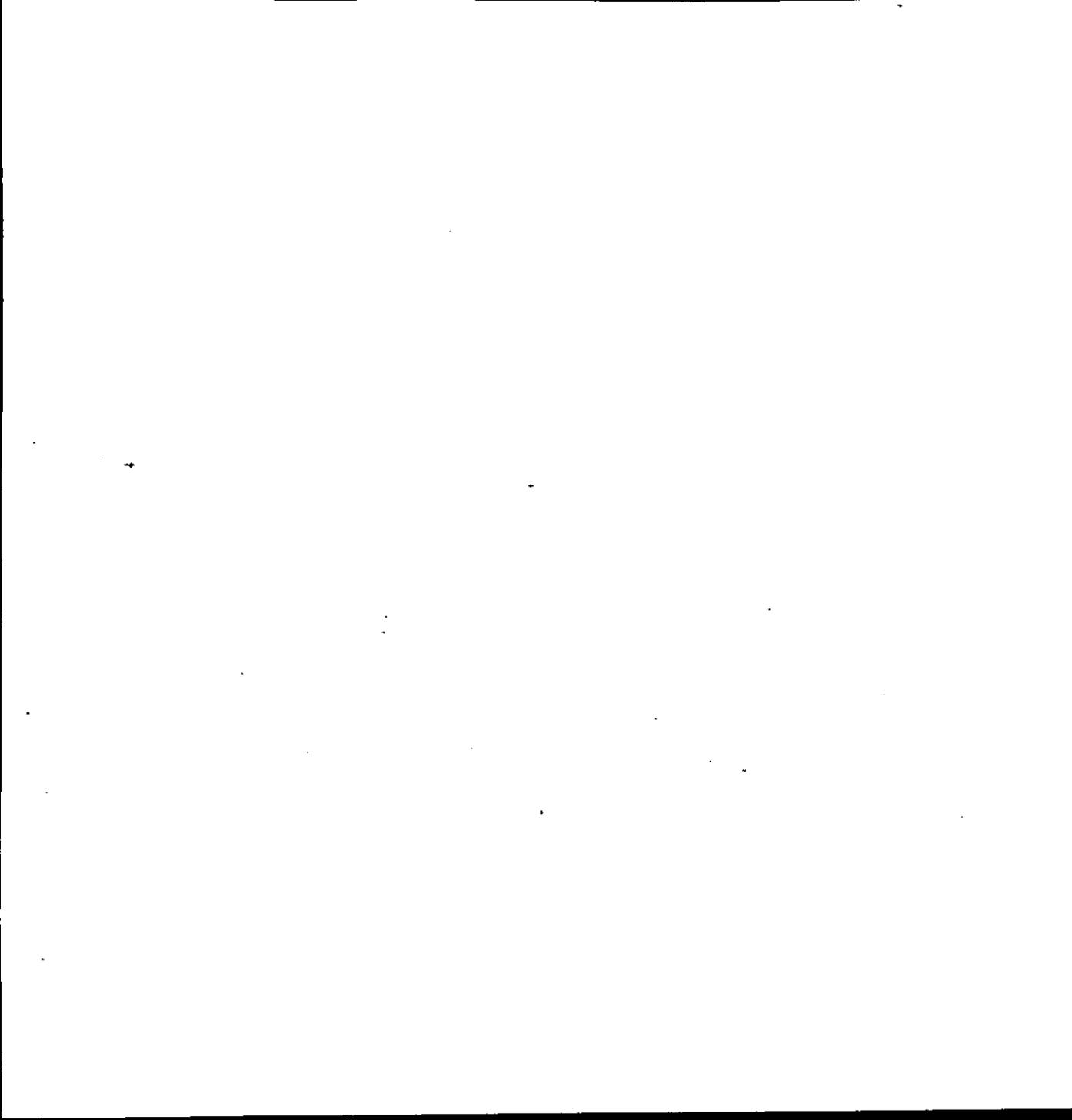
(Signed) Abraham Zaphan M. D.

Sept 18, 1929 (Address) 702 Argyle Bld

\*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 Forest Hill DATE OF BURIAL Sept 21 1929

20. UNDERTAKER Cedar Funeral Home ADDRESS H. C. Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399  
 Township..... Primary Registration District No. 1002  
 City X. City (No. ....) St. .... Ward) 3942

**2. FULL NAME**

Jacqueline Whiteman Carbaugh  
 (a) Residence. No. .... St. .... 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

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

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

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

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT..... (Address)

15. FILED 9/20 1929 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1929

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Myocarditis  
acute osteomyelitis - from  
sepsis (non diabetic)  
 (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Chas. P. Sofner M. D.

hwy. 19 29 (Address) 707 Maple St

\*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

8110E-S