

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

Do not use this space.

30960

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 3385
Township New Primary Registration District No. 3002 Registered No. 3385
City Kansas City (No. 12th St bet Washington & Penn St. Ward)

2. FULL NAME

(a) Residence. No. 1800 West Pennway St. 3 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 8-1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
32 5 14

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work 18th West Pennway
(b) General nature of industry, business, or establishment in which employed (or employer) Mgr Frasier filling station
(c) Name of employer

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

10. NAME OF FATHER Wm Henry Munroe

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

12. MAIDEN NAME OF MOTHER Cora Theresa Robinson

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

14. INFORMANT Mrs Cora Munroe (Address) Tulsa Okla.

15. FILED 9/23, 1929 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/22 1929

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at 4150.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Home made fire arm

173 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1907 (duration) yrs. mos. ds.

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

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

*WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy
(Signed) Stanley M. Hales M. D.
9/22, 1929 (Address) Deputy Coroner

*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 Memorial Park Cemetery DATE OF BURIAL Sept 25 1929

20. UNDERTAKER Eyles Funeral Home 1800 Lenwood ADDRESS

K. 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 PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

176
2

10/10/1954

10/10/54