

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

Do not use this space.

1. PLACE OF DEATH **U.S. VET. HOSPITAL,**

County **JACKSON**  
Township **Kaw**  
City **KANSAS CITY**

Registration District No. **399**

Primary Registration District No. **1002**

(No. **U.S. Veterans Hospital**)

File No. **30981**  
Registered No. **4206**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME **LINDSLEY, Floyd Newton**

C- **None** W.O.E. \_\_\_\_\_

(a) Residence. No. **Independence, Missouri** St. \_\_\_\_\_  
(Usual place of abode)

Ward. **Pvt. Co. I, 17th Reg. Mich. Vol.**  
(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 **WIDOWED**  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **November 5, 1840**

| 7. AGE | YEARS | MONTHS | DAY | IF LESS than 1 day, hrs. or min. |
|--------|-------|--------|-----|----------------------------------|
|        | 88    | 10     | 17  |                                  |

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) **Livonia,**  
(STATE OR COUNTRY) **New York.**

10. NAME OF FATHER **Unknown.**

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

12. MAIDEN NAME OF MOTHER **Unknown.**

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

14. INFORMANT **HOSPITAL RECORDS,**  
(Address) **U.S. VETERANS' HOSPITAL,**  
**Kansas City, Missouri.**

15. FILED **9/24, 1929** **J. M. M. Connor**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **September 22, 1929.**

17. I HEREBY CERTIFY, That I attended deceased from **September 5,** 19 **29** to **September 22,** 19 **29** that I last saw him alive on **September 22,** 19 **29** and that death occurred, on the date stated above, at **7:20 P. m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Chronic Interstitial Nephritis.**

**131**  
**1290**  
Unknown. yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **Unknown.**

DID AN OPERATION PRECEDE DEATH? **NO.** DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? **NO.**

WHAT TEST CONFIRMED DIAGNOSIS? **Laboratory & Physical.**

(Signed) **W. S. Chambers, M. D.**  
**W. S. CHAMBERS, Medical Officer in Charge**  
**U.S. VETERANS' HOSPITAL, Kansas City, Mo.**

(1) 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 Cemetery**

DATE OF BURIAL

**Sept 27, 1929**

20. UNDERTAKER **Mr. Kelly General Home**

ADDRESS **Kansas City**  
**Missouri**

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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