

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

Do not use this space.

34003
4458

1. PLACE OF DEATH
 County Jackson Registration District No. _____
 Township New Primary Registration District No. _____
 City Kansas City (No. 3522 Garfield) St. _____ Ward _____

2. FULL NAME Daniel O. Amess
 (a) Residence. No. 3522 Garfield St. 13 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.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs.	or min.
	<u>74</u>	<u>5</u>	<u>27</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired 8 yrs
 (b) General nature of industry, business, or establishment in which employed (or employer) formally Park Board
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Newark Ohio
 (STATE OR COUNTRY) _____

10. NAME OF FATHER James Amess

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

12. MAIDEN NAME OF MOTHER Mary

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

14. INFORMANT Mrs Mable O. M. Clure
 (Address) 3522 Garfield

15. FILED 10/29/29 M. M. Clure
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Tuesday Oct 29 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Oct 29, 1929 that I last saw ~~him~~ her alive on Oct 29, 1929, and that death occurred, on the date stated above, at 3:59 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
107A
119
Broncho-Pneumonia
 (duration) _____ yrs. _____ mos. 21 ds.

CONTRIBUTORY (SECONDARY) Bronchial Asthma (not Tubercular) (duration) _____ yrs. 5 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? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) A. C. McClure, M. D.
10/29, 1929 (Address) 728 Argyle Bldg N.E. Mo

*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 Memorial Park DATE OF BURIAL 10-30, 1929

20. UNDERTAKER Eggar Funeral Home ADDRESS 1800 Lenwood

MARGIN RESERVED FOR BINDING
 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.

