

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

Do not use this space.

40700

1. PLACE OF DEATH

County Jackson Registration District No. 100
Township Kaw Primary Registration District No. 100
City Kansas City (No. St. Mary's Hosp)

File No. 5105
Registered No. 5105
St. 16 Ward

2. FULL NAME

Samuel Morton Strain
(a) Residence. No. 5646 Bales St., 16 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Ellen E. Strain</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 30, 1873</u>		
7. AGE	YEARS <u>56</u>	MONTHS <u>2</u>
	DAYS <u>9</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Yard Conductor</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer <u>N.C. Southern R.R.</u>		

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Not Known</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Not Known</u>
	12. MAIDEN NAME OF MOTHER <u>Not Known</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Not Known</u>

14. INFORMANT Mrs. Ellen E. Strain
(Address) 5646 Bales

15. FILED 17/11 29 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-9 1929
17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental Rail Road
fracture E. K. E. Yds.
2076
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
Railroad
fracture while working
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
1) DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
17 (Signed) Staley M. Hays M.D.
19 . 1929 (Address) Deputy Coroner

*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 12-11-1929

20. UNDERTAKER J. P. Louis ADDRESS N. E. Me

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.

**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

File No.

Township.....

Primary Registration District No. 1002

Registered No. 3103

City Kansas City (No.)

St. Ward)

2. FULL NAME

Samuel Morton Strain

(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

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M

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

19

Th. M. Brown
Registrar

MEDICAL CERTIFICATE OF DEATH

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

12/9 1929

17.

I HEREBY CERTIFY, That I attended deceased from

19... to 19... that I last saw him alive on 19... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental Railroad
Traumatism

CONTRIBUTORY (SECONDARY)

No auto involved

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)

, 19 (Address)

, M. D

*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

20. UNDERTAKER

ADDRESS

19

SUPPLEMENTARY

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

5-40700