

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

Do not use this space.

5057

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Jean Primary Registration District No. 1684
 City Kansas City (No. Kansas City Gene Hosp) St. Mo Ward 7 E 1

2. FULL NAME

Carl Brundage
 (a) Residence. No. 614 Main St. 1 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED unknown
 (specify the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28-1891
 7. AGE: YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 4 16 _____
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. waiter
 (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) Pa

10. NAME OF FATHER Wm Brundage
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Pa
 12. MAIDEN NAME OF MOTHER Emma Kinnicut
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Pa

14. INFORMANT De wald Clerk
 (Address) Kansas City Gene Hosp

15. FILED 7/16, 1930 M. M. Grove REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1930
 17. I HEREBY CERTIFY, That I attended deceased from 2-9 1930 to 2-14 1930
 that I last saw him alive on 2-14 1930 and that death occurred, on the date stated above, at 9:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Subar Pneumonia
108
110A (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Empyema
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS? Clin. Find. + Autopsy
 (Signed) D. E. Williams, M. D.
2-14, 1930 (Address Subst 75 C. Genl Hosp)

*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 beds. DATE OF BURIAL 2-18-30

20. UNDERTAKER O. V. Mast ADDRESS 1915 E 15

WRITE PLAINLY, 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.

2 242

