

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

Do not use this space.

5059

**1. PLACE OF DEATH**

County Jackson

Registration District No. 399

Township Kaw

Primary Registration District No. 1002

City Kansas City

(No. Kansas City Gen. Hosp)

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

St. 710 (Ward)

**2. FULL NAME**

Bern D. Dole

(a) Residence. No. 510 E. 20th St. 3 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 34 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) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-14-1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
64 11 0

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Common Laborer  
(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) Missouri

10. NAME OF FATHER Chris Dole

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

**14. INFORMANT**

Reverend Clerk  
(Address) Kansas City Gen. Hosp.

**15. FILED**

9/16 1930 M.M. Grove  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-11, 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 2:45 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Streptococic cellulitis of leg  
15%

10 75% (duration) yrs. mos. ds.

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? Clint Lab. Find

(Signed) P. E. Williams, M. D.

2-15, 1930 (Address) Subt 7 C Gen. 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 DATE OF BURIAL

Maple Hill Cem. 2-17-30

20. UNDERTAKER ADDRESS

O. U. Mart 415 E 15th

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.

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