

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

Do not use this space.

5110

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. Densmore Hotel)

Registration District No. 399
Primary Registration District No. 100

File No. _____
Registered No. 768
St. _____ Ward _____

2. FULL NAME John F. Cameron

(a) Residence. No. K.C. Park Hotel 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>About 68</u>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Ry Mail Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). Retired
(c) Name of employer _____

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Coroner's Record
(Address) Kansas City, Mo

15. FILED 7/19 30 Mrs. M. C. Crowe
REGISTRAR Amr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 17 30

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 _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Leucemia, cut throat with rupture

168 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 177 (duration) _____ yrs. _____ mos. _____ ds.

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) Albert J. Carver, M.D.
17, 1930 (Address) Coroner's

*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 <u>Hale, Mo.</u>	DATE OF BURIAL <u>Feb. 20, 30</u>
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20. UNDERTAKER <u>R. V. Lindsey & Sons, Inc.</u>	ADDRESS <u>Kansas City, Mo</u>
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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.

WHILE ENLARGING THIS IS A PERMANENT RECORD

