

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

Do not use this space.

8929

1. PLACE OF DEATH

County Jackson
Township _____
City Kansas City (No. _____)

Registration District No. 357
Primary Registration District No. 100
_____ Mercy Hospital _____

File No. _____
Registered No. 1309
_____ St. _____ Ward)

2. FULL NAME

(a) Residence. No. Marion Kans. St. RR #2 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 (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 5 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 7 18

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Camil Vanderberg

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mullebeke
(STATE OR COUNTRY) Belgium

12. MAIDEN NAME OF MOTHER Margie Vandeburchon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mullebeke
(STATE OR COUNTRY) Belgium

14. INFORMANT Mrs. Camiel Vanderberg
(Address) Marion Kansas RR #2

15. FILED 3/24 1930 M. M. Crowe
REGISTRAR asst

2 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 23 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-20-30 to 3-23, 1930, and that I last saw him alive on 3-23-30, 1930, and that death occurred, on the date stated above, at 4:05 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lymphatic Leukaemia
650 72 B 75 B 2 P
(duration) yrs. mos. ds.
CONTRIBUTORY Acute Cardiac dilatation
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes - 3-23-30

WHAT TEST CONFIRMED DIAGNOSIS S. Pakula, M. D.
(Signed) _____

(Address) Mercy 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

St Josephs Cemetery Mar 25-1930

20. UNDERTAKER Daniels Bros ADDRESS 444 Kansas St
R. E. M.

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.

RECORD

