

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

Do not use this space.

9027

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Beau Primary Registration District No. 1002 Registered No. 1400
 City Kansas City (No. Kansas City Gen. Hosp.) St. Mo. Ward 1103

2. FULL NAME

(a) Residence. No. 14009 Kansas Rd Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 50 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) Dec 25 1866
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 3 5
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Labourer
 (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) Mo.

PARENTS
 10. NAME OF FATHER J. C. Fone
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky
 12. MAIDEN NAME OF MOTHER Martha Randa
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

14. INFORMANT De and Clerk
 (Address) Kansas City Gen. Hosp.

15. FILED 2/31/30 1930 M. M. Labov REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-30 1930
 17. I HEREBY CERTIFY That I attended deceased from 2-4, 1930, to 3-30, 1930 that I last saw him alive on 2-30, 1930 and that death occurred, on the date stated above, at 10:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23F
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 31
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS Gen. Invt. Autopsy
 (Signed) P. P. Williams, M. D.
3-31-1930 (Address) Subt. K. 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 Oak Grove, K.C.Ks DATE OF BURIAL Apr. 1, 1930

20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS K. B. Mo

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.

1-2-1-237

