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

Do not use this space.

12616

1. PLACE OF DEATH

County Jackson — Registration District No. ..... — File No. .....

Township Kaw — Primary Registration District No. ..... — Registered No. 1543

City Kansas City (No. Brookside Hotel St. ..... Ward)

2. FULL NAME Edwin McKaig Clendening

(a) Residence. No. Brookside Hotel St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lide Logan Clendening

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 7, 1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	77	5	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Assistant to President of

(b) General nature of industry, business, or establishment in which employed (or employer) of Chamber of Commerce

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Frankfort Spgs.
(STATE OR COUNTRY) Pennsylvania

PARENTS

10. NAME OF FATHER Dr. John Day Clendening

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

12. MAIDEN NAME OF MOTHER Mary A. Duncan

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

14. INFORMANT Mrs. E. M. Clendening
(Address) Brookside Hotel

15. FILED 4/8, 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 6, 1930

17. I HEREBY CERTIFY, That I attended deceased from 4/6/30 7 am. to time of death, 19..... that I last saw him alive on 4/6, 1930, and that death occurred, on the date stated above, at 12:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Acute Cardiac dilatation caused from Arterio-Sclerosis and mitral insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 900 (duration) several yrs. yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED X

IF NOT AT PLACE OF DEATH X

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. J. [illegible] M. D.

4/7, 1930 (Address) 1203 Wald Lane Bldg Kansas City Mo.

*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~~ Mt. Washington Cem. — DATE OF BURIAL 4-8-1930

20. UNDERTAKER Stine + McClure — ADDRESS 3235 Gillham Plaza.

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.