

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

Do not use this space.

19336

File No. _____
Registered No. 15 2316
St. _____ Ward)

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Raw Primary Registration District No. 1002
City K.C., Mo. (No. Murray Hosp) St. _____ Ward)

2. FULL NAME

Chene Lucille Laidis
(a) Residence No. RR #4 N. K.C., Mo. 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 F 4. COLOR OR RACE W 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) Oct 11 - '24

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
5 7 20

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) K.C., Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Arthur Dennis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Elda Laidis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kansas
(STATE OR COUNTRY)

14. INFORMANT Elda Laidis
(Address) RR #4 N. K.C., Mo

15. FILED 6/2 19 30 M. M. Brown
REGISTRAR Ans

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-1 19 30

17. I HEREBY CERTIFY, That I attended deceased from 6 _____
1 _____, 1930, to 6-1 _____, 1930
that I last saw h.s.x. alive on 6-1-30, 1930, and that
death occurred, on the date stated above, at 11:58 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tetanus
2 1/2 (duration) yrs. mos. 2 ds.
CONTRIBUTORY mail wound
(SECONDARY) (duration) yrs. mos. 1.0 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? Yes
(Signed) C. T. Aldridge M. D.
6/2 19 30 (Address) Murray Hosp 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 Liberty Mo DATE OF BURIAL June 3 1930

20. UNDERTAKER Rose + Henderson ADDRESS 15th Jackson

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.

