

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

Do not use this space.

19535
P. 2535

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 11
 City Kansas City, Mo (No. 5541 Olive Street) St. _____ Ward)

2. FULL NAME Fred C. Hatheway
 (a) Residence. No. 5541 Olive St. 15 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 30 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Mrs. Sadie E. Hatheway
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23, 1877
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 4 25

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Owner of Hatheway
 (b) General nature of industry, business, or establishment in which employed (or employer) Dye House
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Dowagiac, Michigan
 (STATE OR COUNTRY)

10. NAME OF FATHER Gabriel Hatheway
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know
 12. MAIDEN NAME OF MOTHER Dont know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT Mrs. F. C. Hatheway
 (Address) 5541 Olive St.

15. FILED 6/18 1930 M. M. Crowe REGISTRAR
ansr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 1930
 17. I HEREBY CERTIFY, That I attended deceased from March 28 1930 to June 18 1930
 that I last saw him live on June 18 1930 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
720
7703
 (duration) yrs. 1 mos. ds.
 CONTRIBUTORY (SECONDARY) Pleurisy Chronic
(Non tuberculous) (duration) yrs. 1 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? no
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) J. W. Albitan M. D.
June 18 1930 (Address) K.C. 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 Forest Hill Cemetery DATE OF BURIAL 6/19/30

20. UNDERTAKER Freeman Mortuary ADDRESS 104 W 42 St

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.

