

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

Do not use this space.

19737

1. PLACE OF DEATH **Jackson**
 County..... Registration District No. **403**
 Township **Ray Brookbury** Primary Registration District No. **5557**
 City **Kansas City** (No. **Near Highway #50 and the Blue River St.** Ward)

2. FULL NAME **Peter McKay**
 (a) Residence. No. **4404 Montgall** St., **16** 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) **Unknown**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
About 45

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Carpenter**
 (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) **Unknown**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Coroner's Record**
 (Address) **Kansas City Mo**

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-20 1930**
 17. I HEREBY CERTIFY, That I attended deceased from....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Home care fire on
173
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (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? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Autopsy**
 (Signed) **Stanley M. Hall**, M.D.
 6/20 1930 (Address) **Deputy Coroner**

*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 **St. Mary's** DATE OF BURIAL **6/26 1930**

20. UNDERTAKER **R. V. Lindsey & Sons, Inc.** ADDRESS **City**

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 403 File No.
 Township Brookings Primary Registration District No. 5057 Registered No.
 City (No.) St. Ward)

2. FULL NAME

Peter McKay
 (a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
 (c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

FILED 6/22/30 W. W. Hobbs M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 19 30

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*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

20. UNDERTAKER ADDRESS

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, but it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-19737