

SEP 24 1930

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

Do not use this space.

26187

1. PLACE OF DEATH

County CLAY
Township FISHING RIVER
City EXCELSIOR SPRINGS

Registration District No. 198
Primary Registration District No. 3011

File No. _____
Registered No. 78
St. _____ Ward _____

2. FULL NAME

Walter E. Blelock

(a) Residence. No. Snappa Hotel St. _____ Ward Chicago Ill.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 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 (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ray R.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 1874

7. AGE YEARS 56 MONTHS ✓ DAYS ✓ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manager of
(b) General nature of industry, business, or establishment in which employed (or employer) Chicago Bank
(c) Name of employer Mergenthaler

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Penn

PARENTS

10. NAME OF FATHER Walter Kuon

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

12. MAIDEN NAME OF MOTHER Ray Roberts

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

14. INFORMANT Richard E. Blelock

(Address) Chicago Ill.

15. FILED 8/6 1930 J.D. Craven REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) AUGUST 5 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1930, to Aug 6 1930 that I last saw h. Mar. alive on Aug 3 1930, and that death occurred, on the date stated above, at 3 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Dilatation induced by over exertion playing golf on extremely hot day
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Angina Pectoris
(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? History

(Signed) J.E. Musgrave M. D.

8/6 1930 (Address) Excelsior Springs 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

DATE OF BURIAL

Chicago Ill

Aug 6 1930

20. UNDERTAKER

ADDRESS

John C. Prother Ex Springs

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.

**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 Clay Registration District No. 198 File No.
 Township Wheeler Primary Registration District No. 3011 Registered No. 74
 City Wheeler (No.) St. Ward)

2. FULL NAME

(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 (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 10 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 0 0 0 0

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)

15. FILED 1075-30 1930 J.D. Cruey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5 1930

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

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

UNY THEY ARE COMPLETE

REGISTRARS SHALL NOT RECEIVE A FEE

N.B. - This form is to be filled out by the physician or other person who has attended the deceased. It is not to be filled out by the registrar. It is to be filled out in plain terms, so that it may be properly understood. It is to be filled out in plain terms, so that it may be properly understood. It is to be filled out in plain terms, so that it may be properly understood.

SUPPLEMENTARY

S-26187