

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

Do not use this space.

26802

File No. 3407
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County JACKSON Registration District No. 599
Township Rox Primary Registration District No. _____
City KANSAS CITY (No. MERCY HOSPITAL)

2. FULL NAME

GEORGE ONASCH
(a) Residence No. 837 Reynolds ave. N.E. Minn.
(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) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2 1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
8 3 7

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

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

PARENTS
10. NAME OF FATHER Charles J. Onasch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Hedwig Stalling
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany

14. INFORMANT Charles J. Onasch
(Address) 837 Reynolds ave

15. FILED 8/17 1930 M. M. Crowe REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/9/1930
17. I HEREBY CERTIFY, That I attended deceased from 8-3-30 1930 to 8-9 1930
that I last saw him alive on 8-9-30 1930, and that death occurred, on the date stated above, at 2:15 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sarcoma of Left Kidney
one year + (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Intestinal obstruction
Toxemia, Secondary to Sarcoma (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? Yes 8/9/30
WHAT TEST CONFIRMED DIAGNOSIS Lab, clinical & autopsy
(Signed) S. Patula M. D.
8/9 1930 (Address) Mercy Hospital

*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 Hope DATE OF BURIAL 8-11 1930

20. UNDERTAKER Porter & Sons ADDRESS W. E. W.

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.

