

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

Do not use this space.

26891

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kan Primary Registration District No. 1007
 City Kansas City (No. Kansas City General Hospital St. _____ Ward)

File No. _____
 Registered No. 3504

2. FULL NAME

McMurdo Clarence
 (a) Residence, No. T. B. Hospital Less. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alta McMurdo
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-2-1892
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 3 21

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Paper Hanger
 (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) Missouri
 10. NAME OF FATHER Thomas McMurdo
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Recard Black
 (Address) Kansas City Genl Hosp.

15. FILED 9/24 1930 M. M. Kerouche REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-23-1930
 17. I HEREBY CERTIFY, That I attended deceased from 8-12-1930, to 8-23-1930, and that I last saw him alive on 8-23-1930, and that death occurred, on the date stated above, at 6:38 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis Meningitis
J. W. A.
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) J. W. A. (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) P. B. Williams, M. D.
8-24 1930 (Address) Sup. K. C. Genl. Hosp.

*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 Seibel's DATE OF BURIAL 8/25 1930
St. Louis Mo
 20. UNDERTAKER Porter & Eads ADDRESS 17 C K.

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.

