

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

Do not use this space.

29824

1. PLACE OF DEATH

County Jackson Registration District No. 393
 Township Kaw Primary Registration District No. 1003
 City Kansas City (No. Mercy Hospital) St. _____ Ward _____

File No. _____
 Registered No. 3622

2. FULL NAME Della Margaret Halphin

(a) Residence. No. Oak Grove, 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. 1 Hr. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 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) Nov. 19, 1929.
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 14

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

9. BIRTHPLACE (CITY OR TOWN) Oak Grove
 (STATE OR COUNTRY) Missouri

PARENTS
 10. NAME OF FATHER Joseph Halphin
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Missouri
 12. MAIDEN NAME OF MOTHER Opal Robinson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Missouri

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

15. FILED 9/3, 1930 M. R. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 3 1930
 17. I HEREBY CERTIFY, That I attended deceased from _____
 _____, 19____, to _____, 19____
 that I last saw h. _____ alive on _____, 19____, and that
 death occurred, on the date stated above, at 6:20 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
Pneumonia
107A
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 100A
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS Autopsy
9/3 (Signed) Charles M. Crowe M.D.
3, 1930 (Address) By 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 Oak Grove, Missouri DATE OF BURIAL Sep 4 19 30
 20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS Kansas City Mo

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.

