

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

Do not use this space.

30084

**1. PLACE OF DEATH**

County Jac Ks 000  
Township Kaw  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002  
(No. 2544 Summit)

File No. \_\_\_\_\_  
Registered No. 3001  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James S. Dolan  
(a) Residence, No. 2544 Summit St. 3 Ward. \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widower

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
about 54

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

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

10. NAME OF FATHER Martin Dolan

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

12. MAIDEN NAME OF MOTHER Bridget Kennedy

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

14. INFORMANT Mrs. Walsh  
(Address) 2544 Summit K.C. 190

15. FILED 9/23 1930 M. M. Crowe REGISTRAR  
Ans

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 23 1930

17. I HEREBY CERTIFY, That I attended deceased from July 2 1930 to Sept 23 1930 that I last saw him alive on Sept 23 1930 and that death occurred, on the date stated above, at 8:15 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Myocarditis  
93C

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (SECONDARY) Myocarditis, Chronic  
(duration) yrs. 2 mos. 2 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none  
(Signed) J. S. W. Cullbertson M. D.

(Address) Kansas City, 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 Leavenworth Mo. DATE OF BURIAL Sept 25 1930

20. UNDERTAKER J. E. Davis and Co ADDRESS K. O. U. 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.

