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

Do not use this space.

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.: 30087

Township: Raw — Primary Registration District No.: 1002 — Registered No.: [illegible]

City: Kansas City (No. ..... St. Joseph's Hospital St. ..... Ward)

2. FULL NAME Harold Jensen

(a) Residence. No. R.R.7 K.C.K. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Wjite	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 26 1903

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	27		26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Machinist

(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) Kansas

PARENTS

10. NAME OF FATHER: Jens P. Jensen

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

12. MAIDEN NAME OF MOTHER: Marie Peterson

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

14. INFORMANT: Jens P. Jensen
(Address) R.R.7 K.C.K.

15. FILED 9/23, 1930 M. M. Crowe, Asst. REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 22 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-15-30 to 9-22-1930, to ....., 19..., that I last saw h..... alive on 9-22, 1930, and that death occurred, on the date stated above, at 10 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute streptococcus infection of throat septicaemia

115 A (duration) ..... yrs. ..... mos. 4 ds.
36

CONTRIBUTORY (SECONDARY) 109 B1

(duration) ..... yrs. ..... mos. ..... ds.

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

2 DID AN OPERATION PRECEDE DEATH? No. DATE OF 9-15-30

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

9/23, 1930 (Signed) A. J. Welch, M. D.
(Address) 835 Rialto

*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
Mt. Moriah	Sept. 24 1930
20. UNDERTAKER	ADDRESS
H. W. Gates	K.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.