

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

Do not use this space.

30150

1. PLACE OF DEATH

County Jackson
Township Road
City Kansas City (No. Am. Hospital # 2)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 3958
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Unknown 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 colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Unknown
(write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>1/2</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

8. OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(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) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Friend Clerk General Hosp # 2

15. FILED 9/28/30 M. M. Brown REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 13 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1930, to Sept. 13 1930, that I last saw him alive on Sept. 13 1930, and that death occurred, on the date stated above, at 6:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82A
99
_____ (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
_____ (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. M. Miller M. D.
Sept. 13, 1930 (Address) City Hospital No 2

*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 Leeds Farm DATE OF BURIAL 9/30 1930

20. UNDERTAKER West Replying House ADDRESS 600 E. 14th St.

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.

