

**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. 898

File No. 32878

Township Row

Primary Registration District No. St Joseph Hospital

Registered No. 4105
St. 4105 (Ward)

City Kansas City

2. FULL NAME

(a) Residence. No. R.F.D. #1 Merriam Kansas
(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

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)

Sep 11 - 1930

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Merriam

(STATE OR COUNTRY)

Kansas

10. NAME OF FATHER

A R Allmon

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

erie

(STATE OR COUNTRY)

Kansas

12. MAIDEN NAME OF MOTHER

Verna West

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

unknown

(STATE OR COUNTRY)

Oklahoma

14.

INFORMANT

(Address)

A R Allmon
R.F.D. #1 Merriam Kans

15.

FILED

10/9 1930

M M Crowe

asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 8 1930

17.

I HEREBY CERTIFY, That I attended deceased from Oct 5 Oct 5 1930 to Oct 8 1930 that I last saw him alive on 12:30 and that death occurred, on the date stated above, at 1:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Throat

109131

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Convulsions

Oct 8 - 30 6 A.M. 7 1/2 hours

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Home

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

clinical & consult

(Signed) M M Crowe M. D.

10/9 1930 (Address)

742 Maple

*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

Maple Hill Cemetery

Oct 9 1930

20. UNDERTAKER

ADDRESS

Daniels Bros 674 Kansas Ave W.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.

RECORD WITH OUTFACING INK—THIS IS A PERMANENT RECORD

For your copy of the Victoria and
British Columbia