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

Do not use this space.

33102

File No.

Registered No. 1333

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. 1002

City Kansas City (No. Vinyard Park Hospital St. 4333 Ward)

2. FULL NAME Robert S. McBeath

(a) Residence. No. Kidder, 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. 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	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 3, 1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	43	5	23	

8. OCCUPATION OF DECEASED

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

(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) Mo

PARENTS

10. NAME OF FATHER Andrew W. McBeath

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

12. MAIDEN NAME OF MOTHER Mertie Petticord

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

14. INFORMANT Mrs. Estelle McBeath
(Address) Kidder, Mo.

15. FILED 10/26 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 26, 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to Oct 26, 1930 that I last saw him alive on Oct 26, 1930, and that death occurred, on the date stated above, at 12:10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock from Pharyngeal and Gastric Hemorrhage

(duration) yrs. mos. ds. 8 hrs

CONTRIBUTORY (SECONDARY) Arteriosclerosis & Myocarditis Hemorrhagic Diathesis

(duration) 2 yrs. 5 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Tonsils removed DATE OF Oct. 20-30

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J E Sheldon, M. D.

Oct 26, 1930 (Address) Bry Cooper & Bldg 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 Kingston, Mo. — DATE OF BURIAL 10-26-30 19

20. UNDERTAKER Moore, Cameron, Mo. — ADDRESS Kansas City Mo

Office Phone, Victor 4175
Res. Phone, Linwood 2438

J. G. SHELDON, M. D.
ROOM 604 COMMERCE BANK BUILDING
Office Hours: 12 to 4 p.m.

Vineyard Park Hospital
Phone, Grand 3630

℞ For _____ Date _____

Address _____

The arteriosclerosis and associated high arterial tension seemed sufficient cause for the hemorrhage. He had had previous bleedings presumably from the same cause. There was no evidence of ulcer or cancer. J. G. Sheldon

U. S. Reg. No. _____ M. D.

8th and Grand Ave.

10th and Main Sts.

12th and McGee Sts.

728 Minnesota Ave.

1930

S-33102

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1012 Registered No. 4333

City K City (No. ....., ... St. ..... Ward)

2. FULL NAME Robert S McBeath

(a) Residence. No..... 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)
M	W	M

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

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

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

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTY)

14. INFORMANT .....
(Address)

15. FILED 10/26 19 30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 26 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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock from pharyngeal and gastric hemorrhage
.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY (SECONDARY) Arterio sclerosis & Myocarditis hemorrhagic, Diabetes
.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....M. D
, 19 (Address)

*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
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

NG

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