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.: 36281

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

City: Kansas City (No. Kansas City Gen. Hosp. St. ..... Ward)

2. FULL NAME Francis D. DeRone

(a) Residence. No. 1316 Broadway St., 1 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 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	Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 15 1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	49	1	3	

8. OCCUPATION OF DECEASED

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

(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) Ill

PARENTS

10. NAME OF FATHER Earnest DeRone

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

12. MAIDEN NAME OF MOTHER Theresa ?

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

14. INFORMANT Record Clerk (Address) K.C. General Hosp

15. FILED 11/19, 1930 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-18 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-24, 1930 to 11-18, 1930 that I last saw him alive on 11-18, 1930, and that death occurred, on the date stated above, at 2:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Syphilis of central nervous system, Tabes Dorsalis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 38

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. E. Williams, M.D.

11-18, 1930 (Address) Supt K.C. Gen. Hosp

*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: St Marys — DATE OF BURIAL: 11/20 1930

20. UNDERTAKER: [illegible] — ADDRESS: 1915 East 15

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.