

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

Do not use this space.

36337

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Paul Primary Registration District No. _____
City Kansas City, Mo. Locust St

File No. _____
Registered No. 1717
St. 6 Ward) _____

2. FULL NAME

Peray Samuel Lorie

(a) Residence No. 3609 Locust St., 6 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 1, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 2 21

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

9. BIRTHPLACE (CITY OR TOWN) Natchez - Mississippi
(STATE OR COUNTRY)

10. NAME OF FATHER Nathan Lorie

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

12. MAIDEN NAME OF MOTHER Sarah Beckner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Natchez - Miss.
(STATE OR COUNTRY)

14. INFORMANT Jacob Lorie
(Address) 517 East Arrow

15. FILED 11/23/30 M. M. Crow REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb. 11 - 1930, to Nov. 22 - 1930, that I last saw him alive on Nov. 21st - 1930, and that death occurred, on the date stated above, at 4 - A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza, chronic
acute coronary thrombosis
(duration) yrs. 10 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED? 900
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Findings
(Signed) B. S. Sudaisher, M. D.

*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.
11/23/30 (Address) 826 Angyle Bldg -

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cremated Newcomer DATE OF BURIAL Nov 24 1930

20. UNDERTAKER Carol Davidson ADDRESS 3024 Grand

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

