

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

Do not use this space.

39303

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kear Primary Registration District No. _____
City K.C. Mo. (No. 2306 E. 20th St.)

File No. _____
Registered No. 1050
St. _____ Ward _____

2. FULL NAME

James Maurer
(a) Residence, No. 2306 E. 20th St. St. 11 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>negro</u>	5. SINGLE-MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
<u>unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
<u>unknown</u>		
7. AGE	YEARS	MONTHS
	<u>86</u>	
		DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer
(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) Ark
10. NAME OF FATHER Don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs Julia Frazier
(Address) 2306 E. 20th St.

15. FILED 7/1, 1930 M. M. Brown REGISTRAR
Ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 1st 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st to Dec 1st, 1930, and that I last saw him alive on Nov 30, 1930, and that death occurred, on the date stated above, at 1 PM

THE CAUSE OF DEATH* WAS AS FOLLOWS

Chronic Interstitial Ne-
phritis -

CONTRIBUTORY (SECONDARY)

131
F 29 W
(duration) _____ yrs. _____ mos. _____ ds.
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Chronic Nephritis

(Signed) [Signature]
7/1, 1930 (Address) 1716 E. 12th St.

*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 Soldiers Home Remembrance DATE OF BURIAL 12-1-30
19

20. UNDERTAKER Flynn + Greenstreet ADDRESS K.C. Mo.

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.

