

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

Do not use this space.

39509

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Howe Primary Registration District No. _____
 City Kansas City (No. 391) College St. _____ Ward _____

File No. _____
 Registered No. 5182
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. 3917 College St. 16 Ward _____
 (Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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) Mar 24 1918

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
17 6- 23

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City
 (STATE OR COUNTRY) Kansas

10. NAME OF FATHER Frank Manue

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jugo-Slavica
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Anton-Durkovic

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jugo-Slavica
 (STATE OR COUNTRY) _____

14. INFORMANT Frank Manue
 (Address) Kansas City, Kan

15. FILED 12/18 30 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17 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:

Heart failure
167
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 170
 (duration) _____ yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Harold M. Haley M. D.

117 1930 (Address) College

*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 Mt Calvary DATE OF BURIAL 12/19 1930

20. UNDERTAKER M. Skradski ADDRESS K.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.

