

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

Do not use this space.

1459

**1. PLACE OF DEATH**

County Jackson  
Township Kant  
City Kansas City (No. General Hosp # 2)

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 291  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 210 32<sup>nd</sup> Summer 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 <u>Male</u>	4. COLOR OR RACE <u>negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>48</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work musician  
(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 <u>A. Lyons</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo</u>
	12. MAIDEN NAME OF MOTHER <u>P. Moley</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo</u>

14. INFORMANT Clerk  
(Address) General Hospital #2

15. Jan 26 31 M. M. Crowe REGISTRAR  
Ass

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11, 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-1-31, 1931, to 1-11, 1931, that I last saw h. alive on 1-11, 1931, and that death occurred, on the date stated above, at 4:55 P.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Asphyxiation  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Pneumonia  
(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? Autopsy  
(Signed) D.M. Miller, M. D.

1-11-1931 (Address) General Hospital #2  
\*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 \_\_\_\_\_  
Kirksville Mo 1-20-1931

20. UNDERTAKER J.H. Moore ADDRESS 1820 E 18<sup>th</sup>

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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Ed. Exact  
Ed. Exact

D

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
Towaship..... Primary Registration District No..... Registered No. 291  
City..... (No. General Hospital # 2) St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 2832 Juniper 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) .....

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 COUNTRY) .....

10. NAME OF FATHER .....

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

12. MAIDEN NAME OF MOTHER .....

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

14. INFORMANT (Address) .....

15. FILED 1/20 21 M. M. Croove REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 11 19 31

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19....., 19....., and 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:**

CONTRIBUTORY (SECONDARY) Paralysis of Brain (Septic) (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECIPITATE 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 .....

WRITE PLAINLY WITH UNFAADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION; very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-1459