

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

Do not use this space.

1655

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas City

Registration District No. 653  
Primary Registration District No. 101  
(No. 1106 E. 33rd St.)

File No. \_\_\_\_\_  
Registered No. 501  
St. \_\_\_\_\_ Ward

**2. FULL NAME** Albert Slane

(a) Residence. No. 1106 E. 33rd St., 13 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Not known

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
About 35

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Taxi Driver  
(b) General nature of industry, business, or establishment in which employed (or employer). 10<sup>th</sup>  
(c) Name of employer Balek Top TaxinCo.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known 31

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Sam Eisman  
(Address) 32nd & Troost Avs.

15. FILED 7/2 1931 M. M. Grieve REGISTRAR  
Ass

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 1931

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_, and that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Thrombosis  
100A  
111A

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Obliterative left femoral vein (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy (4)

(Signed) Stanley M. Hest M. D.

1/29 1931 (Address) Deputy Coroner

\*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 Shelfield DATE OF BURIAL 2-23 1931

20. UNDERTAKER J.P. Louis Funeral Home ADDRESS 1106 E. 33rd St.

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.

