

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

399

14101

1. PLACE OF DEATH
 County Jackson Registration District No. _____ File No. _____
 Township Rain Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. St. Marys Hospital) St. _____ Ward _____

2. FULL NAME William Garshore
 (a) Residence No. 1002 East 14 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

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 5 - 1876

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>55</u>	<u>55</u>	<u>11</u>	<u>29</u>	

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 4 1931

17. I HEREBY CERTIFY, That I attended deceased from 9-28, 1929, to Apr 4, 1931, that I last saw h. m. alive on Apr 4, 1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Septicæmia
107A
 (duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Bunches - Pneumonia - Resection of knee-joint
 (duration) yrs. 1 mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

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

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 2-23-31

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) J. J. Dorsey, H. D.
4/5, 1931 (Address) 630 Angelle Bldg

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT St Marys Records
 (Address) St Marys Hosp. Kc Mo

15. FILED 4/6 31 M. M. Corowe
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Hill Cemetery DATE OF BURIAL 4-7 1931

20. UNDERTAKER John J. Sheehan 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.

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.....
 Township..... Primary Registration District No..... Registered No. 1609
 City..... St. St. Marys St. Ward)

2. FULL NAME Wm. Borshure

(a) Residence. No. 1002 E 14th 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 M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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.
<u>55</u>				

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 4/6 1931 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 4. 1931

17. I HEREBY CERTIFY, That I attended deceased from 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:

General septicemia

CONTRIBUTORY (SECONDARY) Broncho-pneumonia reaction (duration) yrs. mos. ds. infective mixed joint

18. WHERE WAS DISEASE CONTRACTED Went joint - (duration) yrs. mos. ds. Salvatore's bar seminary

IF NOT AT PLACE OF DEATH: Transmission Nautil full!

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2-23-31

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. J. Dorsey M. D. , 19 (Address) 630 Angyle Bldg

*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

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-14101