

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

Do not use this space.

28375

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City
Lincoln

Registration District No. 389
Primary Registration District No. 3002
(No. Research Hosp.)

File No. _____
Registered No. 3503
St. _____ Ward _____

2. FULL NAME

L. O'neer
(a) Residence No. 3027 Troost

(Usual place of abode) St. _____ Ward _____
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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>About 65</u>	YEARS	MONTHS
	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Abstractor</u> (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) Indiana

PARENTS	10. NAME OF FATHER <u>O'neer</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not Known</u>
	12. MAIDEN NAME OF MOTHER <u>Not Known</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not Known</u>

14. INFORMANT Dr. J. S. Brown
(Address) 6305 W. 80

15. FILED 8/17 1931 M. M. Browne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 14 1931
17. I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1931, to 8-14, 1931, that I last saw him/her alive on 8-14, 1931, and that death occurred, on the date stated above, at 1:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
131
132B
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY chr. glomerulo nephritis
(SECONDARY) _____
(duration) 7 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH Research Hospital
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Tot. Clonus
(Signed) Donald Beach, M. D.
8-14, 1931 (Address) 924 Prof. 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 Forest Hill Cemetery DATE OF BURIAL Aug. 17 1931

20. UNDERTAKER Wagner Funeral Home ADDRESS 204 W. Linwood

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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