

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

Do not use this space.

37875
4743

1. PLACE OF DEATH Veterans' Administration Hospital.

County Jackson Registration District No. _____
Township Raw Primary Registration District No. _____
City Kansas City, Mo. (No. Veterans Administration Hosp) St. _____ Ward _____

2. FULL NAME DeLACERDA, Eddie Edward

(a) Residence, No. 1350 E 13th St. C-320 828 Ward WOE
(Usual place of abode) Des Moines, Iowa. Corp. Co A 2nd F Sig. BN.
(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) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mrs. Jessie DeLacerda**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jan. 7, 1884**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
47 10 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **R R Telegraphar**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Chopin Louisiana**

FATHER 13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT **Hospital Records.**
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **Des Moines, Iowa 11-28-31**

19. UNDERTAKER **Freeman Mortuary & Chapel**
(ADDRESS) **104 W. 42nd St. K. C. Mo**

20. FILED **1/28 1931 M. Crow Registrar.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov. 27, 1931**

22. I HEREBY CERTIFY, That I attended deceased from **October 22, 1931 to November 27, 1931**

I last saw him alive on **November 27, 1931** Death is said to have occurred on the date stated above, at **7:08 P.M.**

The principal cause of death and related causes of importance were as follows:

Adrenal insufficiency 11-27-31

Other contributory causes of importance: **Post operative shock 11-26-31**
Arterio sclerosis (general)

Name of operation **Cholecystectomy** Date of **11-25-31**
What test confirmed diagnosis? **autopsy** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

Ingo, specify _____ (Signed) **William J. Butt**, M. D.
(Address) **William J. Butt**
Officer of the Day

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
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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. 4743
 City..... (No. Veterans Hospital)..... St. Ward.....

2. FULL NAME

Eddy Edo De Lacerda
 (a) Residence. No..... St., Ward. Des Moines Iowa
 (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)

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>47</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....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-27-1931

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:
adrenal insufficiency
68
 CONTRIBUTORY..... P.O. shock (cholecystectomy)
 (SECONDARY) Ren's Arterio sclerosis
 (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? yes DATE OF 11-25-31
 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

20. UNDERTAKER ADDRESS

19

SUPPLEMENTARY

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

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