

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

Do not use this space.

40842

1. PLACE OF DEATH

County Jackson Registration District No. 1006
Township Jackson Primary Registration District No. 1006
City Kansas City (No. 1006) Basin St. 10 Ward 10

File No. 1006
Registered No. 1006
St. 10 Ward 10

2. FULL NAME

(a) Residence, No. 2806 Basin St. 10 Ward 10
(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 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3 - 1873

7. AGE YEARS 58 MONTHS 10 DAYS 29 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Novelty Business

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) See

13. NAME Dont Snow

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Dont Snow

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) United States

17. INFORMANT (ADDRESS) E. H. Layman 2806 Basin

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph DATE 12/4/31

19. UNDERTAKER (ADDRESS) F. J. Donnell 3756 Broadway

20. FILED 173 19 31 M. M. Basin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 7 1931

22. I HEREBY CERTIFY, That I attended deceased from 2/1 1931 to 12/13 1931. I last saw him alive on 12/2 1931. Death is said to have occurred on the date stated above, at 7:30 am. The principal cause of death and related causes of importance were as follows:

1863
1945
59
Diabetes
Other contributory causes of importance:
Fractured arm
Sanguine

Name of operation Amputation Date of 12/13/31

What test confirmed diagnosis? None Was there an autopsy? None

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? None Date of injury None, 1931. Where did injury occur? None (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify None
(Signed) H. S. Shultz, M. D.
(Address) 1215 Kull's Bldg.

**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. 4815
 City..... (No. 2896 Pasco)..... St. Ward)

2. FULL NAME Aaron J. Kayman
 (a) Residence, No. 2806 Pasco 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)

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.
58

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 12/31 1931 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/2 1931

17. I HEREBY CERTIFY, That I attended deceased from
 to 19.....
 (that I last saw h..... also on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured Arm (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Fractured Arm Gangrene
with cross piece of stick left at his home 2 months ago. Injury never healed - gangrene developed here and other parts of body.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) M. D. Prentiss, M. D.
 , 19 (Address) 1215 Realt 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**

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SUPPLEMENTARY

5-40842