

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

Do not use this space.

8313

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. Mersey Hosp. 2) St. _____ Ward _____

File No. _____
Registered No. 876

2. FULL NAME

(a) Residence No. 1909 Laurel St. 12 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 white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25-1931

7. AGE YEARS _____ MONTHS 6 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none
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) Kansas City 1

FATHER 13. NAME Albert Haynes

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

MOTHER 15. MAIDEN NAME Norma Allison

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo.

17. INFORMANT (ADDRESS) Albert W. Haynes
1909 Laurel Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty, Mo. DATE 3-4-32

19. UNDERTAKER (ADDRESS) Mr. C. L. Foster
918 Broadway Ave

20. FILED 1932 M. D. Carroll Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-2-1932

22. I HEREBY CERTIFY, That I attended deceased from 2-18-1932 to 3-2-1932

I last saw h.s. alive on 2-2-1932. Death is said to have occurred on the date stated above, at 2 P. M.

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

Bilateral bronchopneumonia Date of onset ?
107A
89B/107A
Other contributory causes of importance Bilateral otitis media
D

Name of operation _____ Date of _____
What test confirmed diagnosis? laboratory 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? _____
If so, specify _____
(Signed) George X. Campbell, M.D.
Mersey Hospital,
Kansas City,
Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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