

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

Do not use this space.

8332

1. PLACE OF DEATH

County Jackson Registration District No. 526
 Township Law Primary Registration District No. 1002
 City Kansas City (No. 3515) Garner St. _____ Ward _____

2. FULL NAME Iona F. Sinclair

(a) Residence. No. 3515 Garner St. 9 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 6 mos. 0 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert R. Sinclair

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 15 - 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 8 17

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Home 235
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Leavenworth
 (STATE OR COUNTRY) Kansas 2

10. NAME OF FATHER John F. Wills

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

12. MAIDEN NAME OF MOTHER Nancy Randall

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

14. INFORMANT Mrs May Hader
 (Address) 3515 Garner

15. FILED 3/3 3:00 p.m. Carroll REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-2-1932

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1929, to Feb. 28, 1932, that I last saw her alive on Feb. 28, 1932, and that death occurred, on the date stated above, at 3 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
Arterial Hypertension
186A
194B (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Fracture of 1st rib & Fibula
82A (duration) _____ yrs. 6 mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

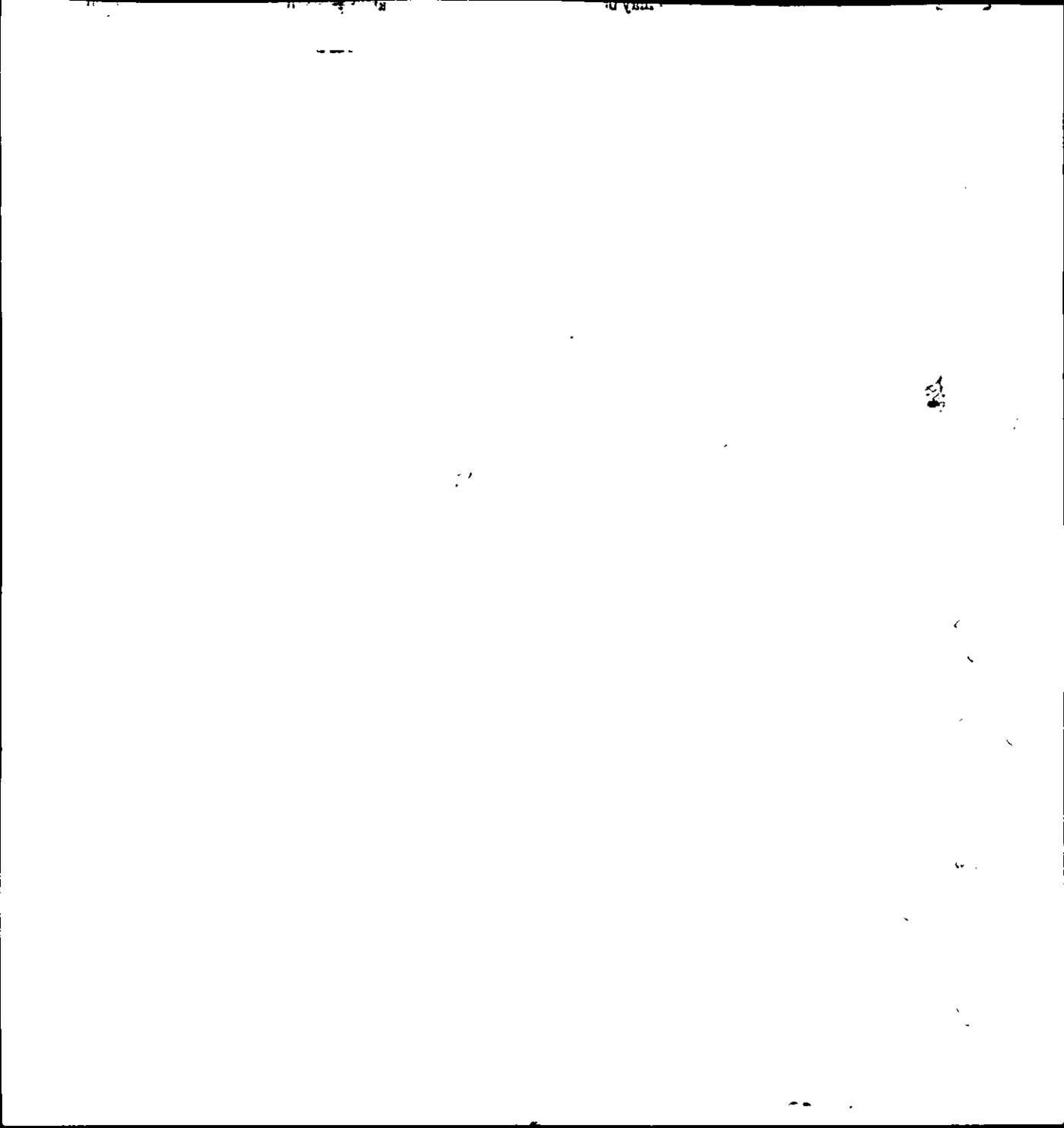
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam -
Dr. W. D. Bishop M. D.
3/2, 1932 (Address) 706 Huron Bldg. CK

*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 Mount Hope R.C. Ch. DATE OF BURIAL 3-4-1932

20. UNDERTAKER Fairweather-Werner ADDRESS 814 N. 7 St



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Keosauqua (No. 3515)

Registration District No. 399
Primary Registration District No. 1002
Jarner

File No. _____
Registered No. 902
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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

MEDICAL CERTIFICATE OF DEATH

3. SEX ♂ 4. COLOR OR RACE _____ 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. 61

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
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) _____

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED Mar 3 1932 M. M. Kerowe Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/2 1932

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Supplementary
arteria sclerosis
1860
Other contributory causes of importance:
Myocardoplexy 1930
united fracture of humerus 1931
fibula

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Acc Date of injury Sept 31
Where did injury occur? Kansas City, Kansas
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
at the patient's home
Manner of injury patient slipped on step
Nature of injury fracture of humerus & fibula

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) M. Bishop M. D.
(Address) 706 Huron Bldg

SUPPLEMENTARY

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

Exact State of Missouri. OCCUPATION IS VERY IMPORTANT. Do not leave blank space unless it may be properly classified.

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