

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

Do not use this space.

8510

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Kaw Primary Registration District No. 1002  
City Kansas City, Mo. Mercy Hospital

File No. \_\_\_\_\_  
Registered No. 1091 (Ward) \_\_\_\_\_  
St. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 3710 Springfield X Rosedale, Kansas  
(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 F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
1 7 5 22

8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc. child  
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 life (years)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

13. NAME Asa T. Bales

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

15. MAIDEN NAME Lillie Perkins

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

17. INFORMANT (ADDRESS) Asa T. Bales  
K.C. Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE Mar 17 - 1932

19. UNDERTAKER (ADDRESS) Gates Funeral Home  
K.C. Kansas

20. FILED 3/16 1932 M.M. Crowe  
cash Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/15/1932

22. I HEREBY CERTIFY, That I attended deceased from 3-11-1932 to 3-15-1932

I last saw her alive on 3-15-1932 Death is said to have occurred on the date stated above, at 1:45 p.m.

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

Bronchopneumonia Date of onset ?  
107A

Other contributory causes of importance:

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 W. M. Howard  
(Signed) Mercy Hospital M. D.  
(Address) Kansas City, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. supplied. AGE should be stated EXACTLY. PHYSICIANS should state

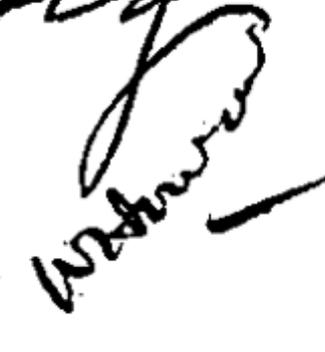
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1/10/50

Acid Broncho  
Cremmonia  
fallaci measles  
or whooping  
cough  



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
Township.....  
City K. City (No.....)

Registration District No. 399  
Primary Registration District No. 1002

File No.....  
Registered No. 1091  
St..... Ward)

**2. FULL NAME**

Olita Bales

(a) Residence, No..... 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (wife the word) A

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.

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)

13. NAME

FATHER  
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

3/16 1932 M. M. Grove Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-15-32

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... 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:

Broncho Pneumonia Date of onset

Other contributory causes of importance: 107a

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?..... 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)....., M. D.  
(Address).....

**SUPPLEMENTARY**

Every effort should be made to obtain information should be 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. REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-8510