

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City, Mo. (No. 1116 Forest)

Registration District No. 800
Primary Registration District No. 1000

File No. 22743
Registered No. 22743
St. Ward

2. FULL NAME Florence Dundag

(a) Residence No. 1116 Florest 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Divorced

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 3, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 0 2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(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) England

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT (Address) Wagner Funeral home
Linwood - N. Grand St.

15. FILED 7/6 1932 M. M. Crowe REGISTRAR
asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5, 32 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1931, to July 4 1932 that I last saw h. or alive on July 4 1932, and that death occurred, on the date stated above, at 7:00 A.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Transition + Acidosis
Gradual April - 1932
following fracture of hip
in Dec 1931 (duration) yrs. 6 mos. 10 da.
CONTRIBUTORY Fracture of hip
(SECONDARY)
Since Dec 22 (duration) yrs. 6 mos. 10 da.
Wound on - non diabetic

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH At place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no (1)

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) E. G. Blair, M. D.
, 19 (Address) 705 Poplar Blvd. K. C. Mo.

*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
Forest Hills Cemetery July 6 1932

20. UNDERTAKER ADDRESS
Wagner Funeral Home 204 W. Linwood

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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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City *X City* (No.....)

Registration District No. *399*
Primary Registration District No. *1002*

File No.....
Registered No. *2648*
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

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*

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.

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

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED *7/6 31 M. M. Crowley* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 5 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:

Infection & accident
fracture of hip
fracture of hip
fracture of hip

Other contributory causes of importance:

fracture of hip

Name of operation *1860* 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 *July 3*

Where did injury occur? *In home*

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *Slipped on rug*

Nature of injury *fracture of hip*

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

If so, specify

(Signed)....., M. D.

(Address).....

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

All information should be carefully supplied. BIRTH in plain terms, so that it may be properly classified.

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SUPPLEMENTARY

5-22743