

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.

36006

**1. PLACE OF DEATH**

County Jackson  
Township Jean  
City Kansas City (No. Kansas City General Hospital St. 1517 Ward)

Registration District No. 399  
Primary Registration District No. 100

File No. \_\_\_\_\_  
Registered No. 1517

**2. FULL NAME**

Pauler Earl  
(a) Residence, No. 1110 Cherry St., 2 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 10 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-10-1872

7. AGE YEARS 50 MONTHS 1 DAYS 17 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. book  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 31  
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) Illinois

FATHER 13. NAME Oscar Pauler

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

MOTHER 15. MAIDEN NAME Arlin Robertson

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

17. INFORMANT (ADDRESS) Recard Clerk, K. S. General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Legdo DATE 11-30-32

19. UNDERTAKER (ADDRESS) Funer & John Funeral Home

20. FILED Nov 20 1932 M. M. Corvone Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-27-1932

22. I HEREBY CERTIFY, That I attended deceased from 11-26-1932, to 11-27-1932.  
I last saw him alive on 11-27-1932. Death is said to have occurred on the date stated above, at 2:34 a.m.  
The principal cause of death and related causes of importance were as follows:

Cardiovascular Disease  
95B  
95B  
Other contributory causes of importance: \_\_\_\_\_  
Date of onset \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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) [Signature] M. D.  
(Address) Gen. Supt. K. S. Genl. Hosp.

