

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Frank
City Kansas City (No. Blue Hoop # 2)

Registration District No. 389
Primary Registration District No. 1002

File No. 1513
Registered No. 243
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2324 Tracy St., 4 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE Colored 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) 7-12-1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 5 26

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Student
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) K.C. Mo.

MOTHER 13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Record Clerk Blue Hoop # 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds mo. DATE 1-17-1933

19. UNDERTAKER (ADDRESS) Hys moore 1620 E. 13th

20. FILED Jan 16 1933 M. M. Crowe Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-8-1933
22. I HEREBY CERTIFY, That I attended deceased from 1-2-1933 to 1-6-1933
I last saw him alive on 1-6-1933 Death is said to have occurred on the date stated above, at 7:20 A.M.
The principal cause of death and related causes of importance were as follows:

Infected cavernous sinus thrombosis
Other contributory causes of importance: T. pneumoniae
Date of onset _____

Name of operation Autopsy
What test confirmed diagnosis St. Clin. & Autopsy 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) J. O. Thomas, M. D.
(Address) Blue Hoop # 2

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

