

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Osaw
City Kansas City (No. K.C. General Hosp)

399
Registration District No. _____
Primary Registration District No. 1002

1572
File No. _____
Registered No. 302
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 4712 1/2 E 24th St. 7 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 19 1876</u>		
7. AGE	YEARS	MONTHS
	<u>56</u>	<u>0</u>
		DAYS
		<u>28</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
<u>Hotel work</u>		
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)		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 17 1933

22. I HEREBY CERTIFY, That I attended deceased from 12-26, 1932 to 1-17, 1933

I last saw alive on 1-17, 1933 Death is said to have occurred on the date stated above, at 9:10 P.M.

The principal cause of death and related causes of importance were as follows:
Carcinoma of Pharynx
Osteomyelitis of Mandible

Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Kansas</u>
13. NAME	<u>Dennis C. Norman</u>
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Ireland</u>
15. MAIDEN NAME	<u>Margaret Blainard</u>
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	<u>Ireland</u>
17. INFORMANT (ADDRESS)	<u>De Wad Clerk K.C. Gen Hosp. K.C. Mo</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE	<u>St. Joseph Hosp</u> DATE <u>1/20 1933</u>
19. UNDERTAKER (ADDRESS)	<u>Melby Melby & Co Kansas City Mo</u>
20. FILED	<u>1-19 1933 M. M. Crowe</u> <u>Regist.</u>

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) J. J. Bennett M. D.
Address St. Joseph Hosp. K.C. Mo

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

