

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

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.

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Kan Primary Registration District No. \_\_\_\_\_  
 City Kansas City No. Kansas City General Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 17982  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 745 Prospect St. 16 Ward.

(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 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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-13-1872

7. AGE YEARS 60 MONTHS 6 DAYS 16 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labourer

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) Indiana

13. NAME John Tinsley

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

15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record, Record Clerk, K.C. General Hospital

17. INFORMANT (ADDRESS) Mollie Watterson, 5400 Woodland

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE Jan-31-33

19. UNDERTAKER (ADDRESS) Mrs. C. L. Corster, 918 Broadway, Ave.

20. FILED Jan 30 19 33 M. M. Crowe Registrar.

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-29-1933

22. I HEREBY CERTIFY, That I attended deceased from 1-23- 1933, to 1-29- 1933

I last saw him alive on 1-29- 1933 Death is said to have occurred on the date stated above, at 9:59 a.m.

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

Coronary Occlusion  
Cytic Regeneration of Brain

Date of onset

Other contributory causes of importance:

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) P. P. De Maria, M. D.

(Address) Asst. Sup. H.C. Gen. Hosp.

100

100