

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

Do not use this space.

19661

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Jean Primary Registration District No. 1902
 City Kansas City (No. 12 C General Hosp) St. St. Louis Ward 15

File No. _____
 Registered No. 2370

2. FULL NAME

(a) Residence, No. 504 W. 14th St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 18, 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 4 18

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

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) Ill

13. NAME Chas. F. Shaw

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

15. MAIDEN NAME Elizabeth Cox

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

17. INFORMANT Beulah Clark (ADDRESS) 12 C Gen Hosp K.C.M.U.

18. BURIAL, CREMATION, OR REMOVAL PLACE Osceola Mo DATE June 6 1933

19. UNDERTAKER Rose Henderson (ADDRESS) _____

20. FILED 6-6 1933 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-6 1933

22. I HEREBY CERTIFY, That I attended deceased from 5-18 1933 to 6-6 1933

I last saw him alive on 6-6 1933 Death is said to have occurred on the date stated above, at 11:50 a.m.

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

Cardiac decompensation

Other contributory causes of importance: None

Name of operation None 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. General M. D.
 (Address) 12 C Gen Hosp K.C.M.U.

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.

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