

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

Do not use this space.

**19952**

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Leavo Primary Registration District No. 1002  
City K.C. 7th (No. 3740) Paseo St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 2670

**2. FULL NAME**

(a) Residence, No. 3740 Paseo St., \_\_\_\_\_ 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug - 24 - 1903

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
69 10 2

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

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) Missouri

13. NAME No Record

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT Orpah Adell Martin

(ADDRESS) 3740 Paseo, Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER Mrs. C. L. Foster

(ADDRESS) 918 Broadway Ave

20. FILED 6-27 19.33 73 73 Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June - 27 - 1933

22. I HEREBY CERTIFY That I attended deceased from June 26 1933, to June 27 1933

I first saw him alive on June 27 1933 Death is said to have occurred on the date stated above, at 4:30 AM

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

Apoplexy Date of onset 6/26/33

Other contributory causes of importance: 820

Name of operation No Date of \_\_\_\_\_

What test confirmed diagnosis? Symptoms Was there an autopsy? No

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? No

If so, specify \_\_\_\_\_ (Signed) P. P. Miller M. D.

(Address) 1115 - E. Harmon

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.

*D. Miller*

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