

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

Do not use this space.

23343

File No. _____
Registered No. **3049**
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. 4922 Wabash)

2. FULL NAME

Otto W. Fairchild
(a) Residence, No. 4922 Wabash 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) 7-8-1879
7. AGE YEARS 54 MONTHS 0 DAYS 18 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Steam Fitter
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 _____

9A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Fairchild

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Butler Mo.
13. NAME Ophir Fairchild
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Armed Mo.
15. MAIDEN NAME Alice Wheaton
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wabash Mo.

17. INFORMANT Alice Fairchild (ADDRESS) 4922 Wabash

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Mariah DATE July 28 1933

19. UNDERTAKER Expans (ADDRESS) T.C. Mo.

20. FILED July 27 1933 P.M. M. Brown Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/26/33
22. I HEREBY CERTIFY THAT I attended deceased from _____ to _____, 19____
I last saw him _____ live on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Chronic Bronchitis
930
94B
Other contributory causes of importance: 930

Name of operation _____ Date of _____
What test confirmed diagnosis? 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) [Signature] (Address) DEPT. OF HEALTH

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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Mr. A. Sanchez