

29 1934

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

Do not use this space.

40383

5194

1. PLACE OF DEATH

County Jackson  
Township Lead  
City Kansas

Registration District No. 399

Primary Registration District No. 1002

(No. 42 C. General Hosp)

File No. 5194

Registered No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. 1521 Central St. \_\_\_\_\_ 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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>not known</u>		
7. AGE	YEARS <u>50</u>	MORTHS _____
	<u>not known</u>	
	DAYS _____	IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	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)	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT Re word Clerk (ADDRESS) 42 C. General Hosp Kansas

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds DATE 1-16-34

19. UNDERTAKER Quinn & Zolner (ADDRESS) \_\_\_\_\_

20. FILED 15-31, 1933 M. M. Crowe Ass't Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-30, 1933

22. I HEREBY CERTIFY, That I attended deceased from 12-28, 1933 to 12-30, 1933

I last saw him alive on 12-30, 1933 Death is said

to have occurred on the date stated above, at 2:10 PM

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

Cystic degeneration of Brain  
Other contributory causes of importance: 87B 87B

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Dr. J. J. ..., M. D.

(Address) 42 C. General Hosp

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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