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.

MAR 24 1934

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1. PLACE OF DEATH

County Buchanan — Registration District No. — File No. 4024

Township X — Primary Registration District No. 1001 — Registered No. 189

City St Joseph (No. State Hospital No.2 St. Ward)

2. FULL NAME Robt White

(a) Residence, No. 329 Bellefountaine St., Ward. Kansas City Mo
(Usual place of abode) Kansas City Mo (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1910

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
24	0	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ~~W.C. White~~

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

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) Unknown. Unknown.

FATHER

13. NAME W.C. White

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. Missouri

MOTHER

15. MAIDEN NAME Unknown.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown. Kansas

17. INFORMANT (ADDRESS) Hospital Records State Hospital No.2

18. BURIAL, CREMATION, OR REMOVAL

PLACE Kansas City Mo. DATE Feb 17 1934

19. UNDERTAKER (ADDRESS) H.O. Sidenfader 1802 Union Street.

20. FILED 2-17-34 John R. Benler Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 16th, 1934

22. I HEREBY CERTIFY, That I attended deceased from Feb 15th, 1934, to Feb 16th, 1934

I last saw him alive on Feb 16th, 1934. Death is said to have occurred on the date stated above, at 9 P. m.

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

Pulmonary Tuberculosis — Date of onset ? Here 2 days

Other contributory causes of importance

Name of operation — Date of

What test confirmed diagnosis? Clinical — 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) J. R. Bunch, M. D.

(Address) State Hospital No 2