

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

Do not use this space.

9172

APR 25 1934

1. PLACE OF DEATH

County Cassion Registration District No. 301
 Township Kaw Primary Registration District No. 1
 City Kansas City Trinity Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Drexel Mo. St. _____ Ward. Drexel Mo.
 (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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>single</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>August 3, 1922</u>		
7. AGE	YEARS <u>11</u>	MONTHS <u>7</u>
	DAYS <u>23</u>	IF LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Student</u>	
	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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1934

22. I HEREBY CERTIFY, That I attended deceased from March 26, 1934, to March 26, 1934
 I last saw h. or alive on March 26, 1934. Death is said to have occurred on the date stated above, at 8 p.m.
 The principal cause of death and related causes of importance were as follows:
Acute rheumatic fever
56a
 Other contributory causes of importance:
Acute filiform diphtheria and bronchopneumonia

Date of entry 3/21/34

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER

13. NAME W. I. Boone

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

MOTHER

15. MAIDEN NAME Margaret Massey

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

17. INFORMANT W. I. Boone, Drexel, Mo.
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Drexel Mo. DATE 3-28, 1934

19. UNDERTAKER Stuart Mc Blue
 (ADDRESS) 3235 William Place

20. FILED 3-27, 1934 anm crow
 Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Joseph Euleker, M. D.
 (Address) 836 Professional Bldg
Kansas City, Mo.

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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