

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

Do not use this space.

SEP 20 1934

29374

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 3729 Baltimore Avenue)

Registration District No. 397
Primary Registration District No. 1002

File No. 3791
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Edmund Dowse Bigelow

(a) Residence, No. 3729 Baltimore Avenue St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 5, 1838

7. AGE YEARS 95 MONTHS 8 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.

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

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) Sherborn Massachusetts

FATHER 13. NAME Amos Bigelow

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sherborn, Massachusetts

MOTHER 15. MAIDEN NAME Lucy Stowe Bigelow

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stowe Massachusetts

17. INFORMANT Edmund S. Bigelow (ADDRESS) 3729 Baltimore Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Washington Cem. DATE August 14, 1934

19. UNDERTAKER Stones & M. Chere (ADDRESS) 3233 Hillman Place

20. FILED 8/13 1934 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 12, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 26, 1934 to Aug 12, 1934

I last saw him alive on Aug 12, 1934 Death is said to have occurred on the date stated above, at 4:15 P.m.

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

apoplexy (central line stroke) Date of onset 108
hypostatic pneumonia & embolism 108

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) E. F. Robinson M. D.

(Address) 928 Prop. Bldg. Kansas City Mo

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.

92 92 22

Progras vna B. 10
No. 4477

Kansas City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Edmund Doucisi Regelow
Who died at _____ on Aug 12 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 95 Months 8 Days 7

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Upopley (Cerebral hemorrhage) Month _____ Year _____
Birthplace (State or country) By Postville Wisconsin
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Family

Other contributory causes of importance _____
Name of operation _____ Date of 11/14/34
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician Dr. E. F. Robinson
Address of physician 928 Prof. Bldg
Signature of Registrar m. m. [unclear] Date filed 9/13/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. _____
Primary Reg. Dist. No. _____
Very truly yours,
E. J. Mc Gaugh
Special Agent.

