

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.

NOV 13 1934

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

Do not use this space.

309

36185

1. PLACE OF DEATH

County JACKSON Registration District No. 1002 File No. \_\_\_\_\_  
Township PAW Primary Registration District No. \_\_\_\_\_ Registered No. 1698  
City KANSAS CITY (No. LAKESIDE HOSPITAL) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME INFANT POPE

(a) Residence, No. 3836 WABASH 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 FEMALE 4. COLOR OR RACE WHITE 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) OCTOBER 21 1934

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
			<u>1</u>	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>NONE</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 _____

12. BIRTHPLACE (CITY OR TOWN) KANSAS CITY  
(STATE OR COUNTRY) MISSOURI

FATHER 13. NAME RALPH E. POPE

14. BIRTHPLACE (CITY OR TOWN) HULL PRAIRIE  
(STATE OR COUNTRY) OHIO

MOTHER 15. MAIDEN NAME VIRGINIA LEE WARNER

16. BIRTHPLACE (CITY OR TOWN) KANSAS CITY  
(STATE OR COUNTRY) MISSOURI

17. INFORMANT MR. RALPH E. POPE  
(ADDRESS) 3836 WABASH AVE.

18. BURIAL, CREMATION, OR REMOVAL PLACE MEMORIAL PARK DATE OCT. 22 1934

19. UNDERTAKER D.W. NEWCOMER'S SONS  
(ADDRESS) 2111 EAST 9TH ST.

20. FILED 10-22 34 M. M. Crowe  
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) OCTOBER 22 1934

22. I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1934, to Oct 22, 1934  
I last saw her alive on Oct. 22, 1934. Death is said to have occurred on the date stated above, at 7:20 A.M.

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

asthenia Date of onset \_\_\_\_\_

159  
1518 159  
Other contributory causes of importance: Prematurity

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Margaret Jones M. D.  
(Address) 5321 Altman Bldg.

