

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

Do not use this space.

JAN 1 8 1935

43298

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Kaw

Primary Registration District No. 1002

City Manassas City

(No. Kansas City Gen Hosp)

File No. _____

Registered No. 5005

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. West Arms Apts Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 19 1874

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>4</u>	<u>17</u>	

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

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) Ind

13. NAME Ernie Gowers

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

15. MAIDEN NAME Mary Link

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

17. INFORMANT (ADDRESS) Reverend Clerk, Kansas City Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds DATE 1-31-35

19. UNDERTAKER (ADDRESS) P B Repetiere, 16th St

20. FILED 12/31-1934 M M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-20 1934

22. I HEREBY CERTIFY, That I attended deceased from 12-19 1934 to 12-20 1934

I last saw him alive on 12-20 1934 Death is said

to have occurred on the date stated above, at 10:20 am

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

Bright Red Date of onset _____
Pneumonia

Other contributory causes of importance: 108

Name of operation _____ Date of _____

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

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) [Signature] M. D.

(Address) St. J. C. Gen 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.

