

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.

JAN 18 1935

43299

1. PLACE OF DEATH

County JacksonRegistration District No. 399Township KanPrimary Registration District No. 1002City KennettNo. Gen Hosp #2

File No.

Registered No. 5089

St.

Ward)

2. FULL NAME

(a) Residence, No. 1717 1/2 Independence St. Ward.

(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

male

4. COLOR OR RACE

Col

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

unknown

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

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

unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ... hrs. or min.

OCCUPATION

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

unknown

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)

unknown

MOTHER FATHER

13. NAME

unknown

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

unknown

15. MAIDEN NAME

unknown

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

unknown

17. INFORMANT (ADDRESS)

Coroner investigator

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Stone Ridge Lane

DATE

1-6-35

19. UNDERTAKER (ADDRESS)

H. B. Brown

20. FILED

12/31-1934 m. m. Brown

Registrar.

MEDICAL CERTIFICATE OF DEATH

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

12-20-34

22. I HEREBY CERTIFY That I attended deceased from

I last saw him alive on 12-20-34 Death is saidto have occurred on the date stated above, 12-20-34

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

Lobar pneumonia

Date of onset

Other contributory causes of importance:

Name of operation

What test confirmed diagnosis

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide

Where did injury occur?

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

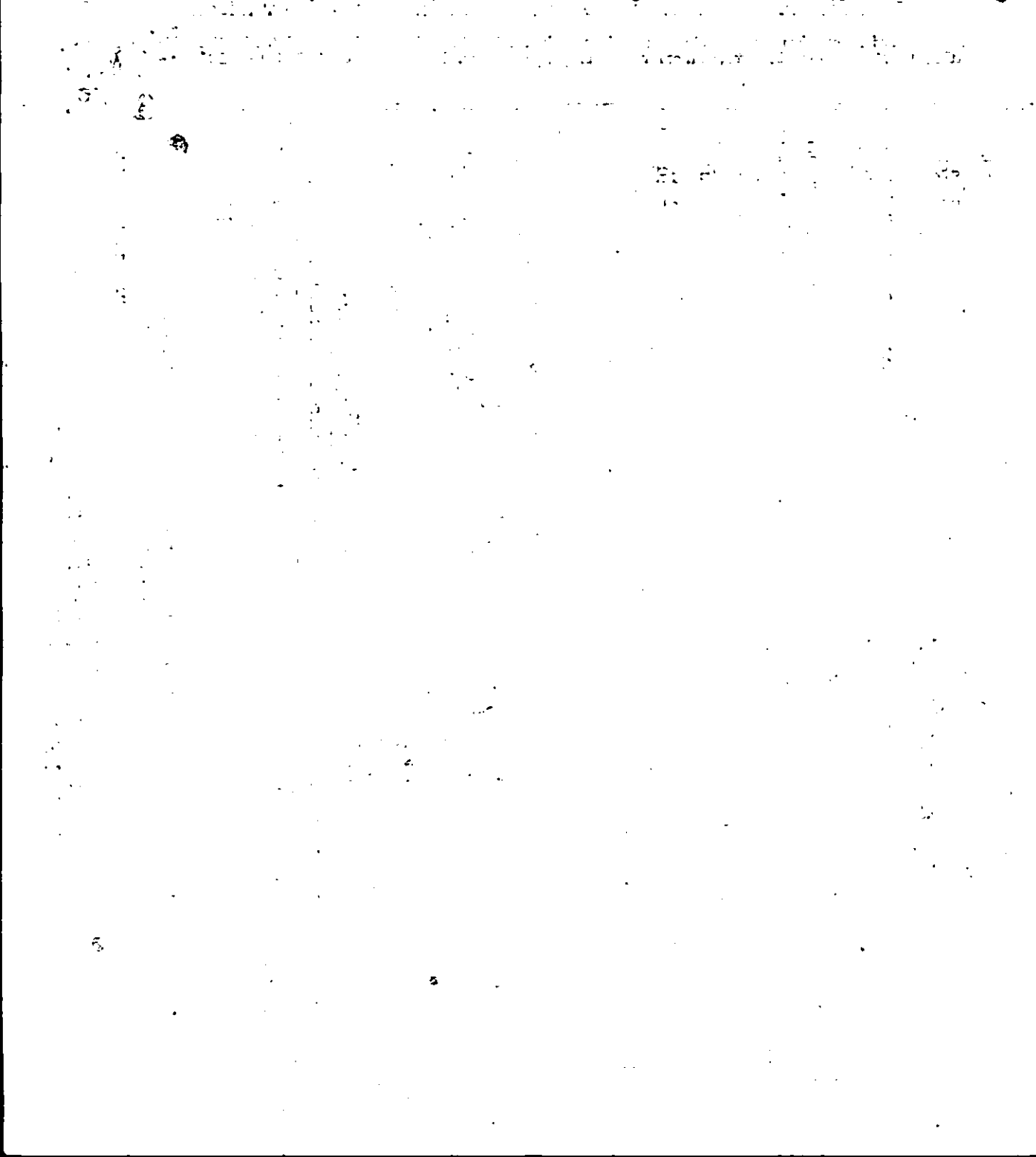
24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

, M. D.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township
City Kansas

Registration District No. 399

Primary Registration District No. 1002

(No. Sen. Hosp #2)

File No.
Registered No. 5687
St. Ward

2. FULL NAME

(a) Residence, No. St. Ward

(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 m 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) un

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

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

7. AGE YEARS MONTHS DAYS about 60 LESS than 1 day, hrs. or min.

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) Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE , 19

19. UNDERTAKER (ADDRESS)

20. FILED 1/31, 19 24 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 20, 19 34

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 .

I last saw him alive on , 19 . Death is said

to have occurred on the date stated above, at m.

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

Date of onset

Other contributory causes of importance:

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) , M. D.

(Address)

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

JAN 24 1935

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