

FEB 29 1935

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

Do not use this space.

1462

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1
Township Frank Primary Registration District No. 1002 Registered No. 223
City Kansas City (No. 72) General Hosp St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3418 Washington 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. 5 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 27 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 mo 24

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

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) mo

13. NAME James Sullivan

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

15. MAIDEN NAME Florence Winder

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

17. INFORMANT Reva Pleck
(ADDRESS) 72 Gen Hosp 72 Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE St Mary DATE 1-23-35

19. UNDERTAKER Durch + John
(ADDRESS) _____

20. FILED Jan 22 1935 W. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-21 1935

22. I HEREBY CERTIFY, That I attended deceased from 1-16 1935, to 1-21 1935

I last saw him alive on 1-21 1935. Death is said

to have occurred on the date stated above, at 7:15 am

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

Bronchopneumonia Date of onset _____

Other contributory causes of importance: none

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? _____

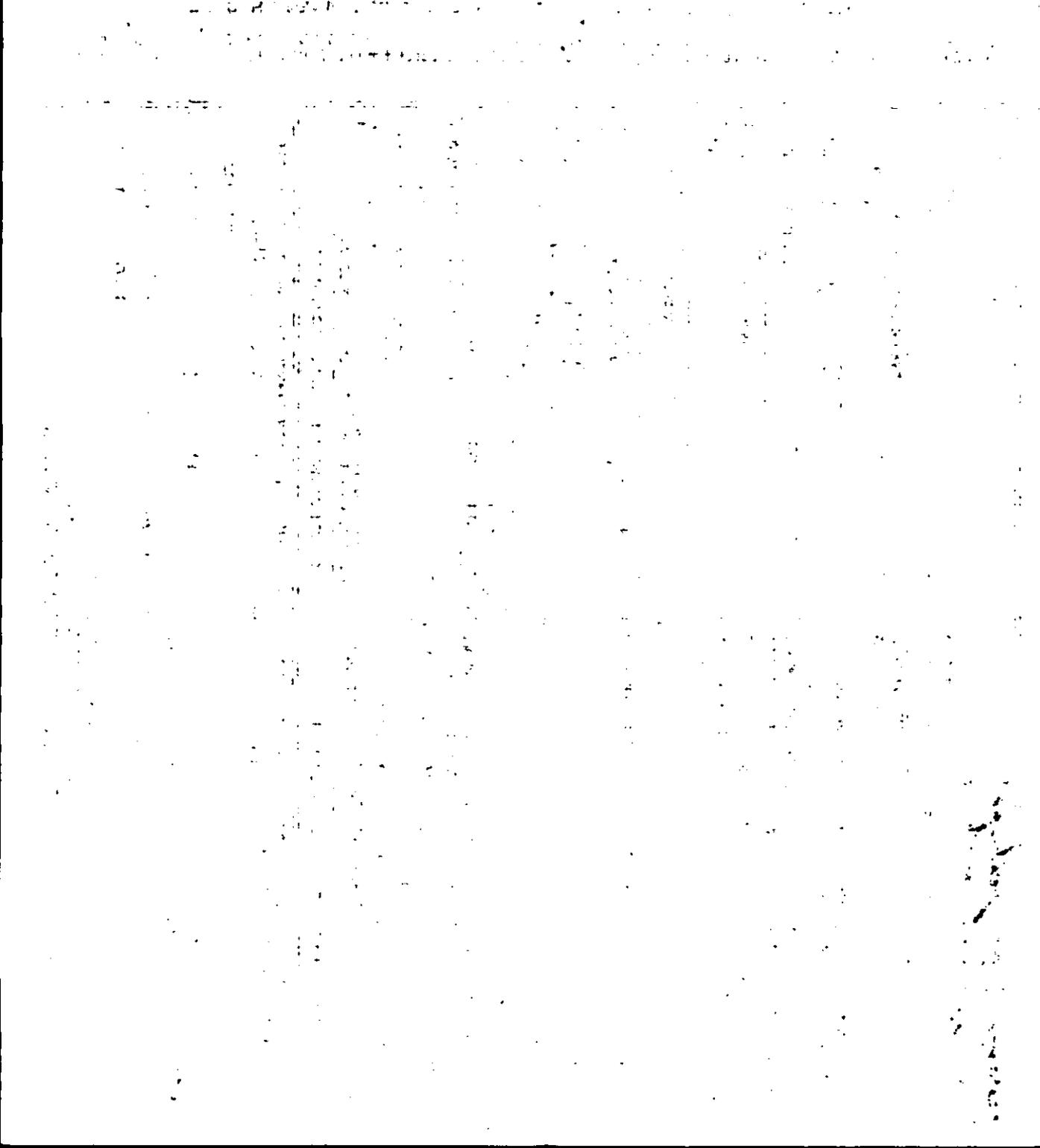
If so, specify _____

(Signed) W. M. Crowe, M. D.

(Address) 72 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.



JUN 7 1935

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 Paris
City Paris

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 328 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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21, 1935

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

22. I HEREBY CERTIFY, That I attended deceased from

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 5 24

, 19, to, 19

I last saw him alive on, 19

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

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

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Bronchitis - pneumonia (Primary) Date of onset

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance: 10/10

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

FATHER 13. NAME

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

MOTHER 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 Jan 22, 1935 M.M. Crowe 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? If so, specify

(Signed) J. H. Jennett M. D.
(Address) J. C. Gen Hosp

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

5-1462