

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

Do not use this space.

MAR 20 1935

1655

1. PLACE OF DEATH

County Jackson
Township Lucas
City Kansas

Registration District No. 153
Primary Registration District No. 153
(No. Mercy Hospital)

File No. _____
Registered No. 1655
St. W Ward

2. FULL NAME

(a) Residence, No. Richard Stone 1124 Garland 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 20-34</u>		
7. AGE YEARS	MONTHS	DAYS
	<u>3</u>	<u>11</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		<u>Infant</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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-31, 1935

22. I HEREBY CERTIFY, That I attended deceased from 12-4, 1934, to 1-31, 1935

I last saw him alive on 1-31, 1935 Death is said to have occurred on the date stated above, at 3:30 PM

The principal cause of death and related causes of importance were as follows:
Influenza
Acute encephalitis 1/30/35

Other contributory causes of importance:
1108

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) Clyde Randall M. D.
(Address) Mercy Hospital

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K 6 Mo

FATHER

13. NAME Granville Stone

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

MOTHER

15. MAIDEN NAME Marion Wink

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

17. INFORMANT Mercy Hospital
(ADDRESS) Independ. Ave. Woodland

18. BURIAL, CREMATION, OR REMOVAL
PLACE Seeds DATE 2-5-35, 19____

19. UNDERTAKER Pety B. Sapetiny
(ADDRESS) 536 Campbell St

20. FILED 7/5 35 M. M. Crowe, east
Registrar.

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.

Was the ~~encephalitis~~
~~epidemic~~ in farm?

Please Final diagnosis
(autopsy)

acute ~~enterocolitis~~ & dehydration
acidosis & cerebral congestion

**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 Registration District No. 399

Township Manassas Primary Registration District No. 1002

City Manassas (No. Mersey Hosp)

File No. 1655
Registered No. 574 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 31, 1935

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

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

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

I last saw h. _____ alive on _____, 19____. Death is said

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

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

The principal cause of death and related causes of importance were as follows: _____ (state of onset)

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 _____

*Acute interstitial renal dehydration
acidosis of ketosis 1 week*

Other contributory causes of importance:

Early interstitial pneumonia

12. BIRTH PLACE (CITY OR TOWN) _____

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 _____

Where did injury occur? _____ (Specify city or town, county, and State)

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR SPENDING

PLACE _____ DATE _____ 19____

Manner of injury _____

Nature of injury _____

19. UNDERTAKER (ADDRESS) _____

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

If so, specify _____

(Signed) Walter Randall M. D.

(Address) Mersey Hospital

20. FILED 35 35 Mr. J. Corow Registrar.

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

OCCUPATION

OTHER CAUSES

