

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

Do not use this space.

5455

MAR 20 1935

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City K.C. Mo. (No. Mercy Hospital)

File No. 100
 Registered No. 100
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2537 Troast 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 F 4. COLOR OR RACE W 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) Aug 10 1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 6 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as planner, 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) Cal

FATHER 13. NAME Elzie J. Holland

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

MOTHER 15. MAIDEN NAME Berghen Rea

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

17. INFORMANT (ADDRESS) Rosa Casson
K.C. Gen Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE 2-18-35 19.

19. UNDERTAKER (ADDRESS) Peter B. Laseberg
536 Cambridge St.

20. FILED 2/18 1935 M.M. Crowe
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16-1935

22. I HEREBY CERTIFY, That I attended deceased from 2-14-1935, to 2-16-1935

I last saw h.s.r. alive on 2-16-1935. Death is said to have occurred on the date stated above, at 4:22 m.

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

Lobar pneumonia Date of onset 2/14/35
Confused broncho
Purulent bronchitis
 Other contributory causes of importance:
Myocardial angina

Name of operation none 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) Alphe K. Randall, M. D.
 (Address) Mercy Hospital

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.

