

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

Do not use this space.

1935

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Wabash Primary Registration District No. 1002
 City Wabash Mo. (No. 2614) St. _____ Ward _____

2. FULL NAME

James Blackwidge Hyde
 (a) Residence, No. 3014 Wabash St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 0 mos. 0 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 6 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 7 15

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinster, sawyer, bookkeeper, etc. Grocery Retailer
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Retail Grocer
 10. Date deceased last worked at this occupation (month and year) 1928 11. Total time (years) spent in this occupation 15

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Andrew Co Missouri

13. NAME Amel C. Hyde

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Andrew Co Missouri

15. MAIDEN NAME Mrs. Blackwidge

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Andrew Co Missouri

17. INFORMANT (ADDRESS) Mrs. J. G. Hyde, 3014 Wabash, Wabash Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph Mo. DATE 6/24 1935

19. UNDERTAKER (ADDRESS) Wabash Mortuary, Wabash Mo.

20. FILE June 21, 1935 M. M. Brown, Reg.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY That I attended deceased from many years to his death, 19 . I last saw him alive on June 6, 1935. Death is said to have occurred on the day stated above, at 6:27 a.m.

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

Senility with Endocarditis

Other contributory causes of importance: Chronic Bronchitis

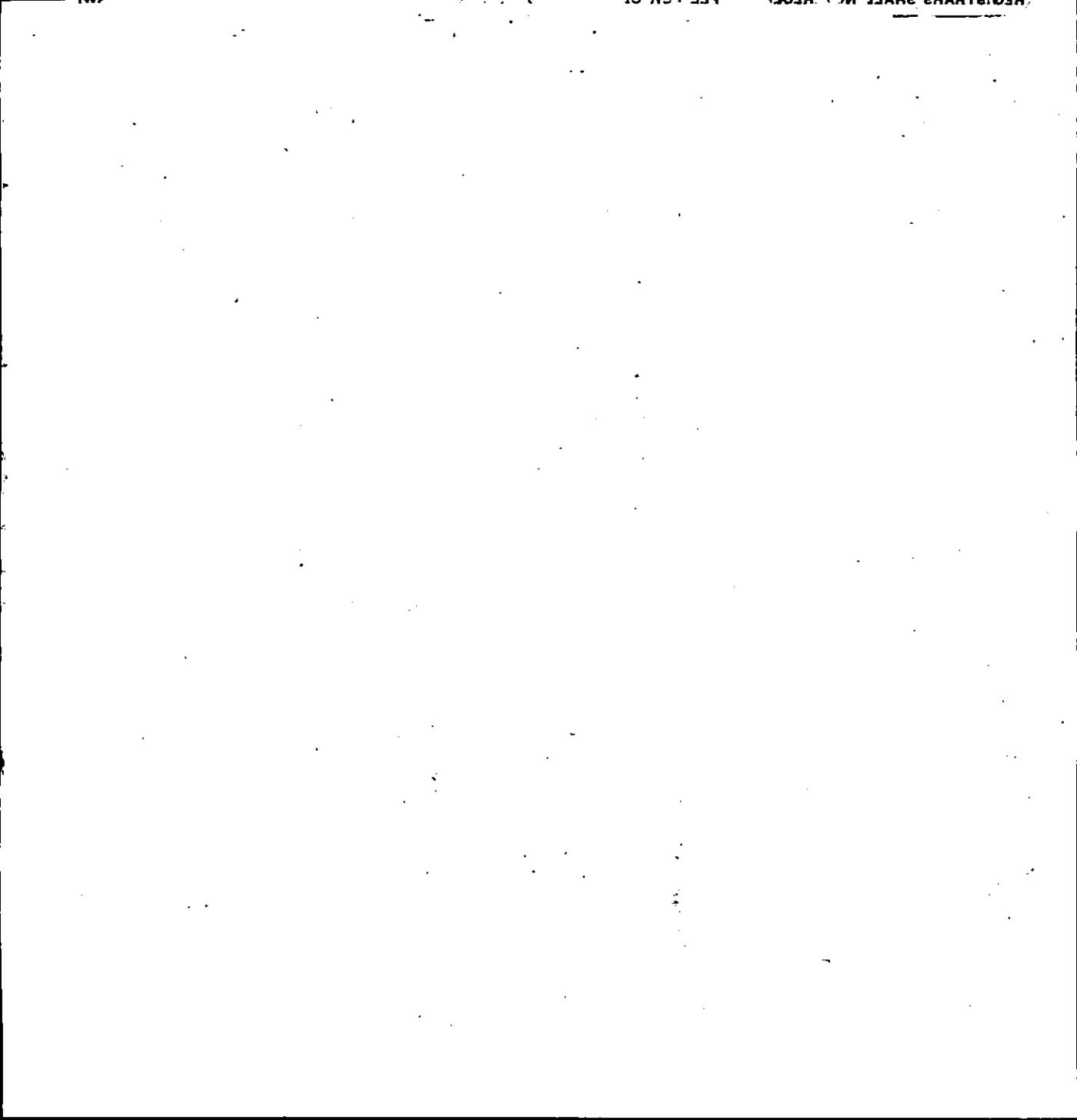
Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Mason B. Alderman, M. D.

(Address) 721 Luther of Kansas City Mo.



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 274
Township..... Primary Registration District No. 1602
City..... KANSAS CITY (No. 3614 Wabash) St. Ward.....
File No.....
Registered No. 2530

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 Male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 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)
11. Total time (years) spent in this occupation

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
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 2/21 19 35 A. M. Corow Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-2-35
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:

Chronic Myocarditis
Chronic Bronchitis
Date of onset 97th
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).....

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