

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.

5740 Central  
AUG 20 1935

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

Do not use this space.

23006

## 1. PLACE OF DEATH

County Jackson  
Township Kaw  
City K.C. Mo

Registration District No. 399Primary Registration District No. 1002(No. Mercy Hospital)

File No. \_\_\_\_\_

Registered No. 23006

St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. Carrollton Mo

(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 Female 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) June 9-357. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 288. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant

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) \_\_\_\_\_

13. NAME William

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

15. MAIDEN NAME Irene

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

17. INFORMANT (ADDRESS) Mrs. W. J. Levy18. BURIAL, CREMATION, OR REMOVAL PLACE Carrollton Mo DATE 7/7 3519. UNDERTAKER (ADDRESS) J. C. Willis Carrollton20. FILED July 7 19 31 M. M. Brown Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17 193522. I HEREBY CERTIFY, That I attended deceased from June 20 1935 to July 7 1935I last saw him alive on July 17 1935. Death is said to have occurred on the date stated above, at 8:42 PM

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

Broncho Pneumonia Date of onset July 1-35

Other contributory causes of importance:

None list  
Cleft PalateName of operation none Date of \_\_\_\_\_What test confirmed diagnosis? none 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.

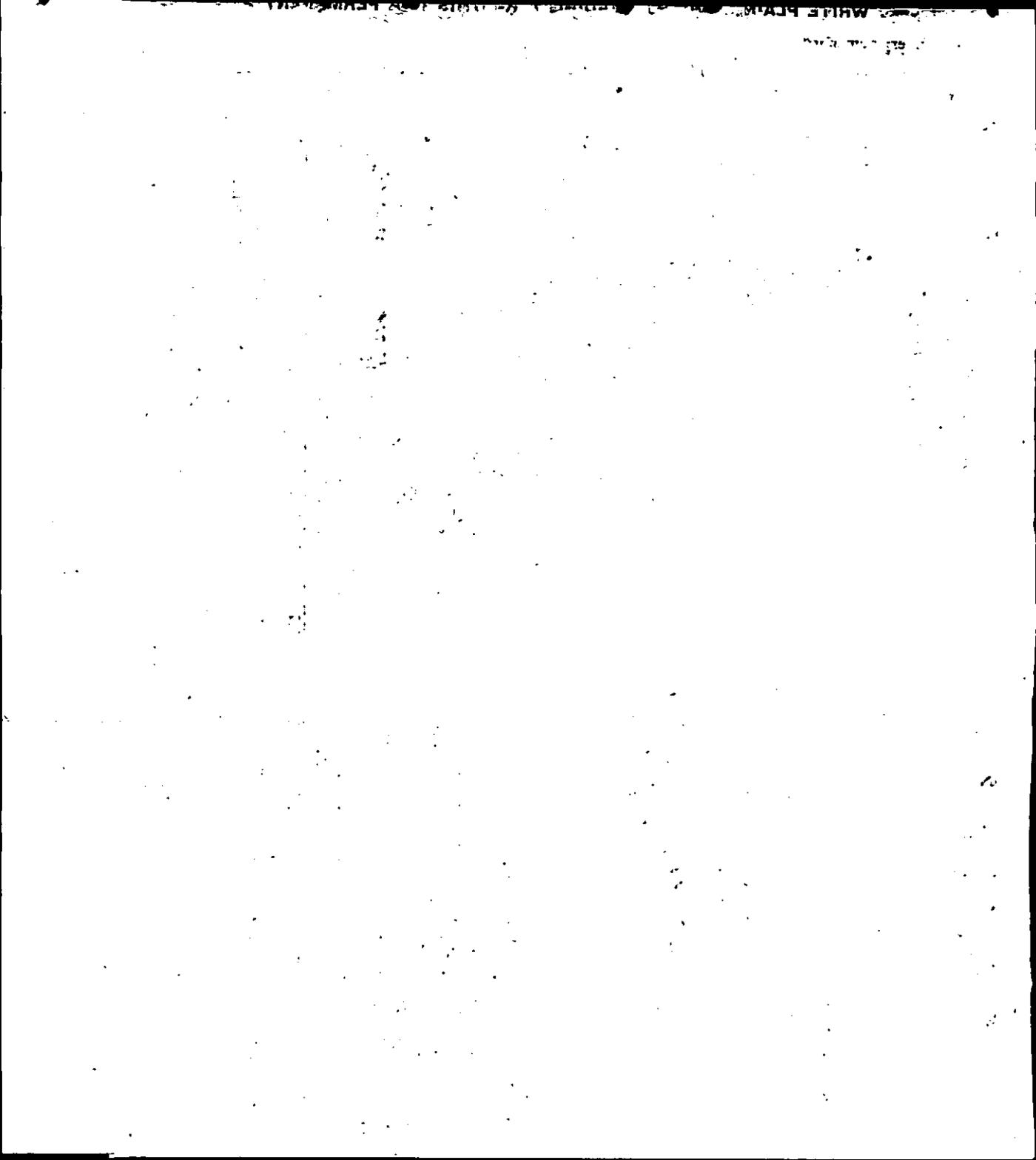
Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) Charles Eldridge M. D.(Address) 6247 Brookside Blvd.



**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..... Registration District No. 399  
 Township..... Primary Registration District No. 1002  
 City..... KANSAS CITY (No. Mercy Hospital) St. .... Ward)

**2. FULL NAME**

(a) Residence, No. .... St. .... Ward. Carrollton Mo.  
 (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 ♂ 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min. 28

OCCUPATION  
 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

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

FATHER  
 13. NAME Wm. Levy

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

MOTHER  
 15. MAIDEN NAME Gene Jones

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

17. INFORMANT (ADDRESS) Melvin Levy

18. BURIAL, CREMATION, OR REMOVAL PLACE Capital Hill DATE 7-8-1923

19. UNDERTAKER (ADDRESS) Melvin Funeral Home

20. FILED 7-9-23 1923 M. M. Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 1923

22. I HEREBY CERTIFY, That I attended deceased from

to, 1923

I last saw him alive on, 1923 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:

Broncho pneumonia Date of onset

No complications

as measles or whooping

Cough

Other contributory causes of importance:

Name of operation

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, 1923

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)

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 COMPLETE AS PRESCRIBED BY LAW

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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