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.

AUG 20 1935

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

Do not use this space.

23085

File No. 2826

Registered No.

1. PLACE OF DEATH

County JACKSON — Registration District No.

Township RAW — Primary Registration District No.

City KANSAS CITY (No. MENORAH HOSPITAL St. Ward)

2. FULL NAME DR. W. ELMER MONTGOMERY

(a) Residence, No. 200-WEST ARMOUR BLVD. Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 47 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: WHITE
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE-18-1874

7. AGE: 13 — YEARS: 61 — MONTHS: 0 — DAYS: 23 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

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

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) JANUARY 1935

11. Total time (years) spent in this occupation 35

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

FATHER

13. NAME WILLIAM MONTGOMERY

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

MOTHER

15. MAIDEN NAME ROXANA CHAPMAN

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

17. INFORMANT (ADDRESS) MRS LOLA A. MONTGOMERY 200-WEST ARMOUR BLVD

18. BURIAL, CREMATION, OR REMOVAL PLACE ELMWOOD DATE JULY 13, 1935

19. UNDERTAKER (ADDRESS) D. W. NEWCOMER'S SONS 211-EAST 9TH ST

20. FILED July 13, 1935 M. M. Crowe, Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 11, 1935

22. I HEREBY CERTIFY That I attended deceased from July 7, 1935, to July 10, 1935. I last saw him alive on 7-10, 1935. Death is said to have occurred on the date stated above, at 4:00 A.m.

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

Amyotrophic Lateral Sclerosis — Date of onset

8 | 0

Other contributory causes of importance:

Bulbar Paralysis

Name of operation none — Date of

What test confirmed diagnosis? none — Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? no — Date of injury, 19

Where did injury occur? no (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 no

(Signed) A. C. Clasen M. D.

(Address) 625 Professional Bldg

625 Professional Bldg
12 -