

16-254

OCT 22 1935

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

Do not use this space.

29472

1. PLACE OF DEATH

County Jackson Registration District No. 39
Township Kans. Primary Registration District No. 1
City Kansas City, Mo., General Hospital St. _____ Ward _____

File No. _____
Registered No. 3451
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. #557 Charlotte 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Unknown

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. app 60

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Do not know

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) Unknown

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT None

18. BURIAL, CREMATION, OR REMOVAL PLACE Local Burial DATE 9/5/35

19. UNDERTAKER O.Y. MAST FUNERAL HOME (ADDRESS) 3146 Main St

20. FILED 9-5-35 M. D. Crown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-4-1935

22. I HEREBY CERTIFY that I attended deceased from _____, to _____, 19____
I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ a.m.

The principal cause of death and related causes of importance were as follows: Auto Alcoholism Date of onset _____

Other contributory causes of importance: 750

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 _____

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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