

OCT 22 1935

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

Do not use this space.

29701

1. PLACE OF DEATH

County Jackson
Township Y-aw
City Kansas City (No. 42 C General Hosp)

Registration District No. 399
Primary Registration District No. 1062

File No. 5877
Registered No. 058043
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 5541 Wayne St., _____ Ward _____

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 3 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
43 1 22

8. Trade, profession, or particular kind of work done, as spinner, 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) mo

13. NAME C. D. Beel

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

15. MAIDEN NAME Ella Link

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

17. INFORMANT Reverend Clerk (ADDRESS) 42 C Gen Hosp PKC mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Methodist DATE Sept 27 1935

19. UNDERTAKER (ADDRESS) W. M. M. Corow

20. FILED Sept 26 1935 W. M. M. Corow Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-25 1935

22. I HEREBY CERTIFY, That I attended deceased from 9-20 1935 to 9-25 1935

I last saw him alive on 9-25 1935, Death is said to have occurred on the date stated above, at 5:25 PM

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

Perirectal abscess; diffuse cellulitis of abdominal wall Date of onset _____

Other contributory causes of importance: lung abscesses

Name of operation _____ 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. _____

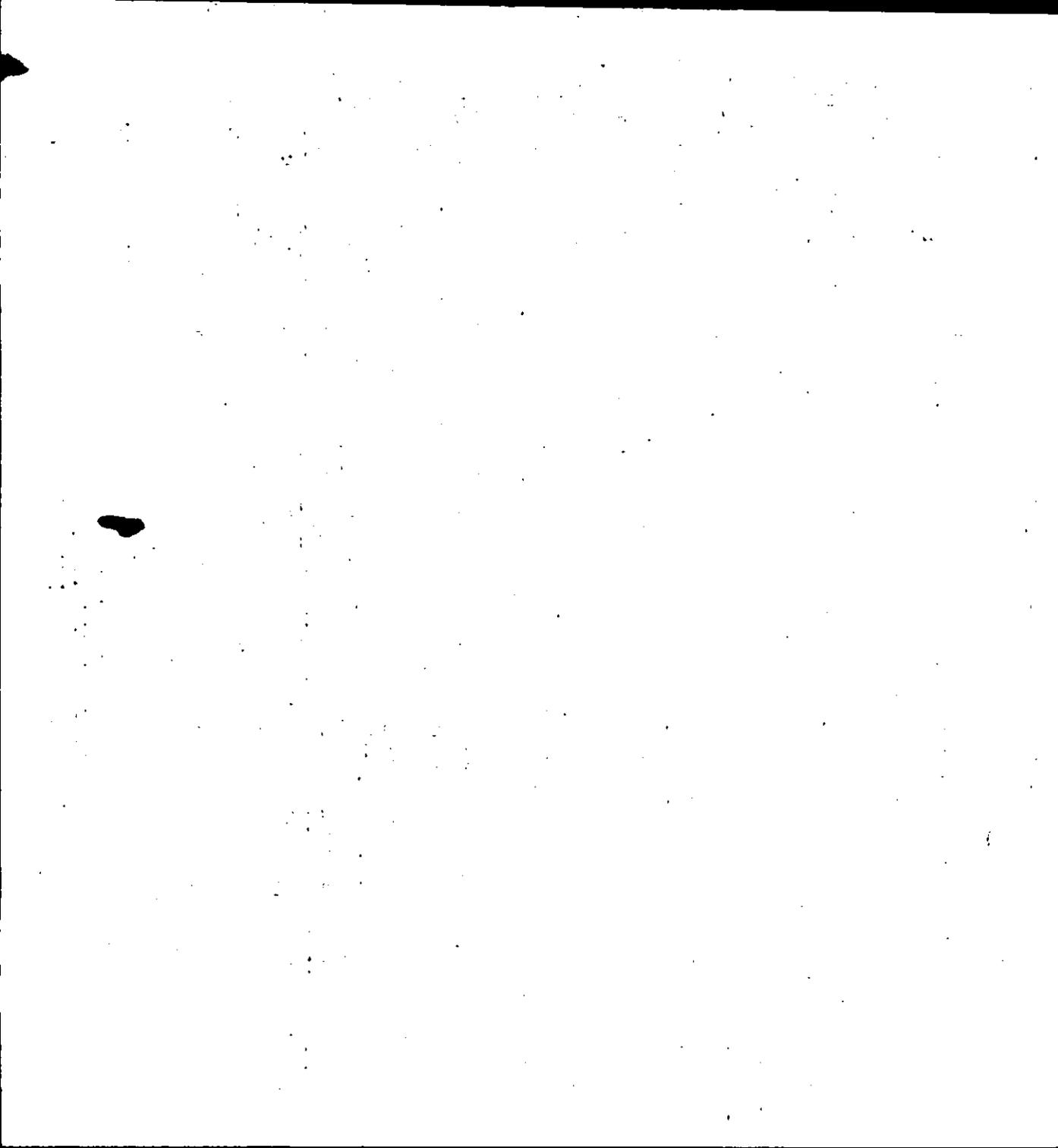
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. M. M. Corow M. D.
(Address) 42 C Gen Hosp PKC mo

This certificate may be properly classified. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. *3714*
 City..... (No. *General Hospital* St. Ward)

2. FULL NAME

Wallace Bell

(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 *M* 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 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

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 *9/26* 19 *31* *M. M. Corrows* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-25-1931*

22. I HEREBY CERTIFY, That I attended deceased from

to, 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:

Perforated abscess, non-tuberculous Date of onset

No further information

Other contributory causes of importance:

lung abscess - Empyema lung abscess - Septicemia

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external cause (violence, fire) 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)

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state

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