

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

Do not use this space.

NOV 21 1935

32644

1. PLACE OF DEATH

County Jackson Registration District No. 352
 Township Kennett Primary Registration District No. 102
 City Kansas City (No. St. Lukes Hospital St. _____ Ward)

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward. Emporia KS
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Fe</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John A Laird</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 9 1870</u>		
7. AGE	YEARS <u>64</u>	MONTHS <u>10</u>
	DAYS <u>7</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>at home</u>	
	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) <u>Kans Mo</u>		
MOTHER	13. NAME <u>James</u> <u>unk</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill</u>	
	15. MAIDEN NAME <u>unk Lambert</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>	
17. INFORMANT <u>Mrs Lucille Laird</u> (ADDRESS) <u>4628 Broadway</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Emporia KS</u> DATE _____ 19__		
19. UNDERTAKER <u>Henry Newman Sons</u> (ADDRESS) <u>Kansas City Mo.</u>		
20. FILED <u>10-5</u> 19 <u>35</u> <u>M. M. Mohr</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 4th 1935

22. I HEREBY CERTIFY, That I attended deceased from Sept 26 1935 to Oct 4 1935
 I last saw him alive on Oct 4 1935. Death is said to have occurred on the date stated above, at 11:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Subsidiary Embolism
 Date of onset 10/4/35

Other contributory causes of importance
Chronic valvular disease of lungs
 6 Mo. ill.

Name of operation _____ Date of _____
 What test confirmed diagnosis? Autopsy 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? No
 If so, specify _____
 (Signed) F. L. Bohan, M. D.
 (Address) West 10th Bldg Emporia

Medical arts Bldg.
