

NOV 21 1935

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

Do not use this space.

32671

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Mad Primary Registration District No. _____
City Kansas City (No. Kansas City General Hospital St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. 4535 Jefferson St., _____ Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 25 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 Barbara Regdale
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-14-1850
7. AGE YEARS 85 MONTHS 7 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. 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) Kentucky

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Robert Clark
(ADDRESS) K. B. General Hospital

18. BURIAL, CREMATION, OR REMOVAL Forest Hill DATE Oct 9 1935

19. UNDERTAKER Wm. J. Henderson
(ADDRESS) R. C. 2nd

20. FILED 10/8 1935 m. m. Crowe

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-7-35

22. I HEREBY CERTIFY, That I attended deceased from 9-2- 1935, to 10-7- 1935
I last saw him alive on 10-7- 1935 Death is said to have occurred on the date stated above, at 11:45 a.m.

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

Hypostatic Bronchitis
Pneumonia
Chronic Myocarditis

Date of onset

Other contributory causes of importance:

Bilateral Pyelonephritis
Cystitis

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) P. F. De Mana, M. D.
(Address) Asst. Supr. K. B. General Hospital

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

