

NOV 21 1935

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

Do not use this space.

32828

1. PLACE OF DEATH

County Jackson

Registration District No.

Township W. 1st

Primary Registration District No.

City W. B. Mo.(No. 2330 Norton)

File No.

Registered No.

St. Ward)

2. FULL NAME

(a) Residence, No. 2330 Norton 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 M4. COLOR OR RACE Wh.5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 28, 18747. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 6 21

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) Henry Co. Mo.
(STATE OR COUNTRY)13. NAME Matthew W. Kirk14. BIRTHPLACE (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)15. MAIDEN NAME Mary C. Jones16. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)17. INFORMANT A. B. Kirk
(ADDRESS) 2330 Norton18. BURIAL, CREMATION, OR REMOVAL
PLACE Quincy, Mo. DATE Oct 21, 193519. UNDERTAKER W. B. Anderson
(ADDRESS) 713 E. 15th20. FILED 10-21-35 M. M. Crew
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 19, 1935

22. I HEREBY CERTIFY, That I attended deceased from

, 19....., to....., 19.....

I last saw him alive on....., 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:

Date of onset

Lympho-sarcoma
Lies metastasis

Other contributory causes of importance

Cachexia

Name of operation..... Date of.....

What test confirmed diagnosis? X-ray Was there an autopsy? Yes

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?.....

(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) Maxwell R. Renshaw M. D.(Address) Bell Works R.C. Mo.

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.

Kick

Wesley. Rumold.

Medical Arts Bldg.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City..... (No. St. Ward)

File No.....
Registered No. 4008

2. FULL NAME Linnis Mabelle Kirk

(a) Residence, No. 2330 Norton St. Ward.....
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(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. 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 10/21 1925 Wm. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 19, 1930

22. I HEREBY CERTIFY, that I attended deceased from October 18 1935 October 19, 1930
I last saw him alive on October 19, 1930. 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:

Sarcoma
Lympho sarcoma
Lymph nodes on left side
Other contributory causes of importance:
of neck according to
history. General lymph
node metastasis when
I saw her.

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....., 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) Merim G. Raymond M. D.
(Address) Medical Arts Bldg
Kansas City Mo

SUPPLEMENTARY

S-32228