

DEC 26 1935

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

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36240

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kane Primary Registration District No. 5788
 City Kansas City (No. Memorial Hosp) St. 44th Ward

File No. _____
 Registered No. _____

2. FULL NAME

(a) Residence, No. 3305 Faced 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) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-22-1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 1

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child

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) Kansas City Mo

13. NAME Robert Nagle

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

15. MAIDEN NAME Ruth Sequest

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo

17. INFORMANT Robert Nagle (ADDRESS) 3305 Faced

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Ignace DATE 11-24-1935

19. UNDERTAKER J. P. Louis Funeral Home (ADDRESS) City

20. FILED 11-24-1935 J. M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-22-1935

22. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1935 to Nov 22, 1935

I last saw him alive on Nov 22, 1935. 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:

Pneumonia Date of onset

Other contributory causes of importance: Upper Respiratory Infection

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.....

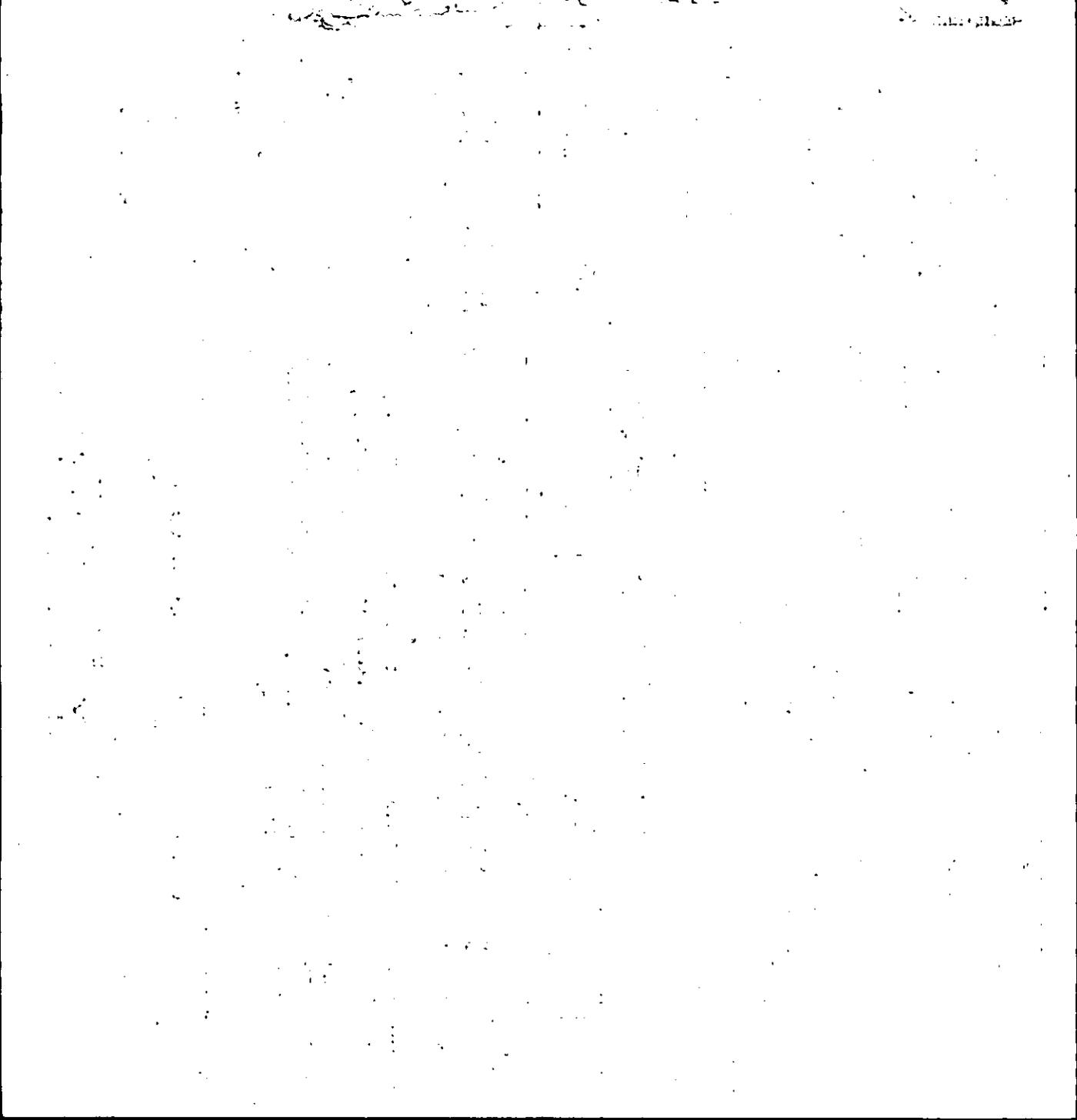
Nature of injury.....

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

If so, specify..... (Signed) Philip S. Watson, M. D.

(Address) 400 Nagle Bldg

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**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..... File No.....
 Township..... Primary Registration District No..... Registered No. 4468
 City..... (No. Memorial Hospital St. Ward)

2. FULL NAME

Ronald Magle
 (a) Residence, No. 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 22, 1935

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

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

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

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at..... m.

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

Bropters pneumonia Date of onset

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.....

Other contributory causes of importance: Upper respiratory infection
Influenza

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

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

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

What test confirmed diagnosis?..... Was there an autopsy?.....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

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

Where did injury occur?..... (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury.....

PLACE..... DATE....., 19.....

Nature of injury.....

19. UNDERTAKER (ADDRESS)

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

20. FILED 11-24, 1935 M. M. Corwell Registrar.

If so, specify.....

(Signed)....., M. D.

(Address).....

SUPPLEMENTARY

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

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