

JAN 15 1936

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan
Township
City St Joseph (No. State Hosp #2)

85

Registration District No. 1001 4
Primary Registration District No. 1001 4

File No. 38609

Registered No. 1274
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward. Kansas City, Mo.
(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? 7 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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 16 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 1 18

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

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) Jackson Co Mo

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS) Records State Hosp. St Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE KC, Mo DATE Dec 6 1935

19. UNDERTAKER (ADDRESS) Wagner F. Howe

20. FILED 12-4 1935 John R. Beardsley Registrar

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, That I attended deceased from June 2nd 1930, to Dec 4 1935

I last saw him alive on Dec 4 1935 Death is said

to have occurred on the date stated above, at 10:00 a.m.

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

Lobar Pneumonia Date of onset Dec 1st

Other contributory causes of importance: Fractured Femur 154

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide Accident Date of injury Nov 27, 1935

Where did injury occur? State Hospital - St Joseph (Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place. State Hosp - Accident - Fall

Manner of injury Accidental - Fall on floor

Nature of injury Fractured Femur

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) W. Clayton Smith, M. D.

(Address) State Hosp #2

St Joseph 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.

