

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.

16-288

WM LAGEY

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

Do not use this space.

MAR 21 1936

1667 D  
540

1. PLACE OF DEATH

County Jackson Registration District No. \_\_\_\_\_  
Township Kear Primary Registration District No. \_\_\_\_\_  
City Kansas City, Mo (No. 817 Main St in Street)

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Wm Lagey WM LAGEY  
(a) Residence, No. 274 E Bellevue St., \_\_\_\_\_ Ward. \_\_\_\_\_

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Unknown</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Unknown</u>		
7. AGE YEARS <u>app 74</u>	MONTHS	DAYS
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Do not know</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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-25-1936

22. I HEREBY CERTIFY That Wm Lagey died on \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, Mo. I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 9:30 a.m.

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

Other contributory causes of importance:  
None

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Do not know</u>
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL no final nec. DATE 2/3/36 19\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

19. UNDERTAKER Of Mass Funeral Home (ADDRESS) 3146 Main St

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) \_\_\_\_\_, M. D.  
(Address) \_\_\_\_\_

20. FILED 2-1 1936 M. M. Cron, Dist Registrar.

