

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.

JUL 24 1936

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

Do not use this space.

23059

1. PLACE OF DEATH

County Jackson  
Township Kaw  
City Kansas City

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 29992  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. 1505 E 22nd Terrace 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 <u>Fe</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 31, 1933</u>		
7. AGE	YEARS	MONTHS
	<u>2</u>	<u>5</u>
		DAYS
		<u>21</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		IF LESS than 1 day, ..... hrs. or ..... min.
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) <u>Kansas City Mo.</u>		
13. NAME <u>James Hetherington</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Arkansas</u>		
15. MAIDEN NAME <u>Eva Boyd</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Arkansas</u>		
17. INFORMANT <u>Eva Hetherington</u> (ADDRESS) <u>1505 E 22nd Terr.</u>		
18. BURIAL, CREMATION, OR REMOVAL <u>Blue Ridge Lawn</u> DATE <u>June 24 1936</u>		
19. UNDERTAKER <u>Hatkins Bros.</u> (ADDRESS) <u>1724 17th Street</u>		
20. FILED <u>7/24 1936</u> <u>M. M. Brown</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 21, 1936

22. I HEREBY CERTIFY That I attended deceased from 6/14/1936 to 6/21/1936  
I last saw him alive on 6/21/1936. Death is said to have occurred on the date stated above, at 169 a.m.  
The principal cause of death and related causes of importance were as follows:  
Tuberculous meningitis Date of onset ?  
9 yrs  
Other contributory causes of importance:  
Purulent otitis media ?  
Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical Was there an autopsy? no

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? no  
If so, specify \_\_\_\_\_  
(Signed) Wm. C. Caldwell M. D.  
(Address) 2131 E. 24th St.

