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.

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

Do not use this space.

44805

JAN 20 1937

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kan — Primary Registration District No. 1002 — Registered No.

City Kansas City (No. Arlene Hotel, 1000 E 30th St. Ward)

2. FULL NAME Albert Edward Espey

(a) Residence, No. 1000 E. 30th St., Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
65			

OCCUPATION

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Employee

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) Illinois

FATHER

13. NAME James H. Espey

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

MOTHER

15. MAIDEN NAME Roxana Mathery

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

17. INFORMANT (ADDRESS) James W. Espey

18. BURIAL, CREMATION, OR REMOVAL PLACE Sioux City, Iowa DATE 12-14 1936

19. UNDERTAKER (ADDRESS) Carroll Davidson 3624 Troost

20. FILED Dec 14 1936 M. M. Crowe Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-12, 1936

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

I last saw h.... alive on 1 Apr 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
Chronic epilepsy	

Other contributory causes of importance:

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) [signature], M. D.

(Address) [signature]