

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.

1. PLACE OF DEATH

County JacksonRegistration District No. 399Township KawPrimary Registration District No. 1002City Kansas City, Mo. (No. K. C., Indust. Hoop)File No. 48110Registered No. 47

St. _____ Ward _____

2. FULL NAME Infant Armstrong(a) Residence, No. 7700 E 17th St. 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 <u>Male</u>	4. COLOR OR RACE <u>White</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>4/5/36</u>		
7. AGE YEARS	MONTHS	DAYS
<u>Stillbirth</u>		
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>none</u>		11. Total time (years) spent in this occupation _____
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) _____		
12. BIRTHPLACE (CITY OR TOWN) <u>Kansas City, Mo.</u> (STATE OR COUNTRY)		

MOTHER	13. NAME <u>William Armstrong</u>
	14. BIRTHPLACE (CITY OR TOWN) <u>Mo.</u> (STATE OR COUNTRY)
FATHER	15. MAIDEN NAME <u>Ilabelle Edson</u>
	16. BIRTHPLACE (CITY OR TOWN) <u>Mo.</u> (STATE OR COUNTRY)
17. INFORMANT <u>William Armstrong</u> (ADDRESS) <u>7700 E 17th St.</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Floral Hills</u> DATE <u>4/6/36</u> 19. _____	
19. UNDERTAKER <u>Sheil Funeral Home</u> (ADDRESS) <u>6606 Indep. Ave., K. C., Mo.</u>	
20. FILED <u>Apr 6 1936 M. M. Brown</u> Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>4/5</u> 19 <u>36</u>
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ I last saw him alive on <u>4/5</u> , 19 <u>36</u> . Death is said to have occurred on the date stated above, at <u>8.00 P.M.</u> The principal cause of death and related causes of importance were as follows: <u>Birth injury</u> <u>Respiratory failure</u> Other contributory causes of importance: _____ Name of operation _____ Date of _____ What test confirmed diagnosis? _____ Was there an autopsy? <u>No</u> 23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury <u>4/5</u> , 19 <u>36</u> Where did injury occur? <u>Birth</u> (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 <u>Birth injury</u> 24. Was disease or injury in any way related to occupation of deceased? <u>No</u> If so, specify _____ (Signed) <u>Ernest Albers</u> , M. D. (Address) <u>920 Newton Ave</u>

