

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

Do not use this space.

AUG 11 1937

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Townsh. 1 Primary Registration District No. 1002 File No. 26186
 City Kansas City (No. 2) Trinity Lutheran Hospital Registered No. 2000 Ward 2

2. FULL NAME Adler Masters
 (a) Residence, No. _____ St. _____ Ward. Miami Co. Kan
 (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 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) May 7 1926

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>11</u>	<u>1</u>	<u>24</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

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) Johnson Co Mo

13. NAME A. A. Masters

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

15. MAIDEN NAME Leda Brown

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

17. INFORMANT A. A. Masters
(ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Padon Kans DATE 7/8 1937

19. UNDERTAKER (ADDRESS) J. J. Wehlers
2704 Kansas

20. FILED 7-6 1937 M. M. Crowe, cash
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7 - 6 , 1937

22. I HEREBY CERTIFY, That I attended deceased from 7 - 4 , 1937, to 7 - 6 , 1937
 I last saw her alive on 7 - 6 , 1937 Death is said to have occurred on the date stated above, at 8:15 P.M.

The principal cause of death and related causes of importance were as follows:
Septicemia associated with Streptococci following a strep throat
 Date of onset _____

Other contributory causes of importance: 1150

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? 6/20

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) R. J. Structuresen , M. D.
 (Address) 1934 Argyle Bldg
R. E. McO.

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.

2099

