

SEP 21 1937

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Jackson  
Law  
Kansas City, Mo

Registration District No.

Primary Registration District No.

399

1002

File No.

Registered No.

29781

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

Ruth Roe Marie Danah  
Gashland Mo R 1

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *Wht* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 2 / 1912*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *25 0 25*

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

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) *La*

13. NAME *Fred Smith*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *La*

15. MAIDEN NAME *Anna Hopman*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *La*

17. INFORMANT (ADDRESS) *Art Danah  
Gashland, Mo R 1*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Res. Monies, La Aug 17 1937*

19. UNDERTAKER (ADDRESS) *Moston, F. H.  
no. K. E. Mo*

20. FILED *Aug 17 1937 M. M. Crow, reg*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 16 1937*

22. I HEREBY CERTIFY, That I attended deceased from *June 17 1937*, to *Aug 16 1937*. Next saw him alive on *Aug 16 1937*. Death is said to have occurred on the date stated above, at *3.0* m.

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

*Sub-diaphragmatic abscess  
(Sub-diaphragmatic abscess)*

Other contributory causes of importance: *Sub-acute Pleurisy  
etiology unknown*

Name of operation *Drainage of abscess* Date of operation *8/16/37*  
What test confirmed diagnosis *nothing* Was there an autopsy *yes*

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) *H. H. H. H.* M. D.  
(Address) *M. M. Crow, reg*

WRITE PLAINLY IN UNFADING INK—THIS IS

MEMORANDUM: 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.

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CONVICTION  
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PEACE

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

29987X  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 399  
 (b) Township ..... Primary Registration District No. 1002  
 (c) City N. C. Mo (d) Street No. .... St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 3415

**2. PRINT FULL NAME**

Ruth Rose Marie Danesh  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M  
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
25 0 25

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/17 1937 M. M. Brown  
 Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 12 1937

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

I last saw him alive on ..... 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:

Tubercular abscess  
etiology unknown  
 Date of onset

Other contributory causes of importance:

Tubercular abscess  
etiology unknown

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 H. Langhart, M. D.

(Address) North N.C. Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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