

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

Do not use this space.

NOV 18 1937

36743

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township 1st Primary Registration District No. _____
City Kansas City (No. General Hosp. # 2)

File No. _____
Registered No. 6010 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Old Folsom Name St. _____ Ward _____

(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 Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
About 73

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
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) Unknown

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) None

18. BURIAL, CREMATION OR REMOVAL PLACE Blue Ridge Lawn DATE 10/18/37

19. UNDERTAKER (ADDRESS) Wm. Appleton Jones Inc. 1905 Pine St.

20. FILED 10-18, 1937 m m Crowe, asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-15-37

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 9:30 p.m.

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

Cerebral Sclerosis
Chloroform Hypocautic
93C

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? Culture 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? _____

If so, specify Russell W. Bass, M. D.
(Signed) _____

(Address) _____

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.

