

REC'D MAY 10 1939

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

Do not use this space.

14026

1. PLACE OF DEATH

County Jackson 3 Registration District No. 395
 Township Raw Primary Registration District No. 1002
 City Kansas City, Mo. (No. 504 Benton Blvd.)

File No. _____
 Registered No. 1780
 St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. 5420 Albert Inboes Ward. _____
 (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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sophron Inboes6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct - 24 - 49

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 6 3

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Copper
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. H. Milling Co.
 10. Date deceased last worked at this occupation (month and year) 1938 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio13. NAME Wm Inboes14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record15. MAIDEN NAME Wm. D. Inboes16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record17. INFORMANT (ADDRESS) Sonsville Martin
2618 Bellvue18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE 11-29 193919. UNDERTAKER (ADDRESS) Sales Terminal Home20. FILED Apr. 28 1939 M. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 27 193922. I HEREBY CERTIFY, That I attended deceased from 2-10 1939 to 4-27 1939I last saw him alive on 4-27 1939. Death is saidto have occurred on the date stated above, at 3:40 P.M.

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

Hypostatic pneumonia 4-19-39
 Congestive Heart failure 4-26-39
 Other contributory causes of importance:
 Arterial sclerosis
 Senility

Name of operation None Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? No23. 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) Lawrence W. Brummon, M. D.
 (Address) 3200 Indep. Ave.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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NOT REPRODUCIBLE

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14026
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....
(b) Township..... Primary Registration District No..... Registered No. 1780
(c) City..... (d) Street No. 504 Benton 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.

2. PRINT FULL NAME *Albert Indrea*

(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 *Male* 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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.
89

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

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED *4/28 1939 M. H. Brown*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-27-1939*

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

I last saw h..... 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:

Hyperstatic Pneumonia
Bronchial

Coronary Heart Failure

Other contributory causes of importance: *107.2*

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) *S. W. Blum*, M. D.

(Address) *3200 Indes Ave*

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

