

DEC 26 1935

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

Do not use this space.

36310

1. PLACE OF DEATH

County Jackson Registration District No. 10
Township Yaw Primary Registration District No. 10
City Kansas City (No. 1) K. C. Gen. Hosp. St. 15th Ward)

2. FULL NAME

(a) Residence, No. 365 E 9th St., Sam Lawrence 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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 / 1 / 23

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) Clinton Mo

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT Deane Clark (ADDRESS) 2000

18. BURIAL, CREMATION, OR REMOVAL PLACE Clinton DATE Nov 29, 1935

19. UNDERTAKER Mrs. V. E. Foster (ADDRESS) 718 Broadway, etc.

20. FILED 11-29-35 M. M. Crow Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-29, 1935

22. I HEREBY CERTIFY, That I attended deceased from 11-28, 1935, to 11-29, 1935

I last saw him alive on 11-29, 1935. Death is said to have occurred on the date stated above, at 8:10 A.M.

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

Mitral Insufficiency
Chronic Glomerular
Nephritis

Date of onset

Other contributory causes of importance:

Bronchopneumonia

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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.....

(Signed) M. M. Crow, M. D.

(Address) 2000

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.

THIS IS A PERMANENT RECORD

