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

Do not use this space.
57 1470

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City (No. 127 Linwood Blvd. St. Ward)
Registration District No.
Primary Registration District No.
File No.
Registered No.

2. FULL NAME: Mrs Agnes M. Thompson
(a) Residence. No. 127 Linwwod St., 5 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

48
10
9

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe.
4. COLOR OR RACE: Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: James O. Thompson

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

7. AGE: about 67 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): New York

PARENTS
10. NAME OF FATHER: Robert Farrell
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Mary Connell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): Ireland

14. INFORMANT: James O. Thompson
(Address): 127 Linwood Blvd.

15. FILED 1/5, 1929 M M Cline Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1928, to Jan 3, 1929, that I last saw him alive on Jan 3, 1929, and that death occurred, on the date stated above, at 4:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardio-renal vascular complex
131 /
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H A Breyfogle, M.D.
1-4-29, 1929 (Address) 918 Medical Arts Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt. Moriah Receiving vault
DATE OF BURIAL: Jan 5 1929

20. UNDERTAKER: Funeral Mortuary
ADDRESS: 104 W. 42nd

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 CERTIFICATE, WHEN COMPLETED, WITH STRIKING INFORMATION IS A PERMANENT RECORD

15-2-2235

1225 W.60 Terrace

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 57

City..... (No. 127 Linwood Blvd St. ..... Ward)

2. FULL NAME Mrs Agnes M. Thompson

(a) Residence. No. 127 Linwood St., ... Ward. .....
(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	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.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 1/5, 1929 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at .....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
	Mar 28 1929
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

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

S-1470