

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

Do not use this space.

10798

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 1307
Registered No. 1307
St. _____ Ward _____

2. FULL NAME

Joseph Edwin Sawyer
(a) Residence No. 5824 Lee St. _____ 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)** Baby

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 13 - 1927

7. AGE YEARS MONTHS DAYS | **IF LESS than 1 day,** hrs. min.
2 | 2 | 0 | 0 | 0 | 0 | 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child
(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) Kans. City Mo.

10. NAME OF FATHER David G. Peter Sawyer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Jill

12. MAIDEN NAME OF MOTHER Lena Soranto

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kans. City Mo.

14. INFORMANT (Address) Mrs. Patricia Soranto Kans. City Mo.

15. FILED 3/15 29 M.M. Lamm 1929

REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1929 to Mar 13 1929, that I last saw him alive on Mar 13 1929, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia + Emphysema

CONTRIBUTORY (SECONDARY) 1000

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) H. Ramsey M. D.

3/14 1929 (Address) 311 Argyle Bldg

*State the DISEASE CAUSING DEATH, or in cases 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

Calvary Cem.

3/16 1929

20. UNDERTAKER

ADDRESS

The Taylor Funeral Home

Kans. City Mo.

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.

311 Wiggins
Pharmacy