

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

Do not use this space.

10847

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 309
Primary Registration District No. 1002
(No. 710 Euclid Ave.)

File No. 1357
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Grant Buzzard
(a) Residence, No. 710 Euclid Ave., St. 2 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 19th, 1866</u>		
7. AGE YEARS <u>64</u>	MONTHS <u>8</u>	DAY <u>29</u>
If LESS than 1 day, _____ hrs. or _____ min.		

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

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

10. NAME OF FATHER B. D. Buzzard

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

12. MAIDEN NAME OF MOTHER Armina Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT Wm. E. Buzzard
(Address) 710 Euclid Ave

15. FILED 3/19, 1929 M. M. Crowne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-18 1929

17. I HEREBY CERTIFY, That I attended deceased from May 1924 to Mar. 18 1929
that I last saw alive on Mar. 18 1929, and that death occurred on the date stated above, at 7:10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Cardiac Dilatation
14A
750

CONTRIBUTORY Angina Pectoris
(SECONDARY) (duration) 4 yrs. 10 mos.

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

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF _____
WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DEATH? Clinical
(Signed) [Signature] M. D.
3/17 1929 (Address) 215 W. 12th St. 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 Holden Mo. DATE OF BURIAL 3/19 1929

20. UNBERTAKER The Taylor Funeral Home
ADDRESS [Address]

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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