

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

Do not use this space.

10850
1360

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Law Primary Registration District No. 1502
 City Kansas City (No. Genl. Hosp # 2)

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

2. FULL NAME

(a) Residence No. 1809 Forest St. 3 Ward. (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 <u>M.</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unk 1880</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>49</u>			
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Com labourer</u>				
(b) General nature of industry, business, or establishment in which employed (or employer)				
(c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) <u>not known</u> (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER <u>not known</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>			
	12. MAIDEN NAME OF MOTHER <u>unknown</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>			
14. INFORMANT <u>Mrs. M. Murray</u> (Address) <u>15116 12th</u>				
15. FILED <u>3/19 29</u> <u>M. M. Corneil</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-12-29

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.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Receded haemorrhage
 (duration) _____ yrs. _____ mos. _____ ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS Autopsy
 (Signed) Deputy Coroner, M. D.
 (Address) Deputy Coroner

*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 Highland Cem DATE OF BURIAL 3/19 29

20. UNDERTAKER Watkins Bros ADDRESS 1729 Lydia

WRITE FAINLY, 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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