

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

Do not use this space.

21581 2720

1. PLACE OF DEATH

County Jackson
Township Flaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

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

2. FULL NAME

(a) Residence. No. 4526 So Beeman St., 16 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U.S., if of foreign birth? yrs. moa. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6 - 1893

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 11 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer W S Dechy Clay Co

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER Michael Condon

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

12. MAIDEN NAME OF MOTHER Calherine Toohy

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

14. INFORMANT Mrs Rhoda Condon
(Address) 4526 So Beeman

15. FILED 6/19 29 M. M. Cross REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1929

17. I HEREBY CERTIFY, That I attended deceased from June 12 1929, to June 17 1929 that I last saw him alive on June 12, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicaemia
176
26 (duration) yrs. mos. 5 da.

CONTRIBUTORY (SECONDARY) Infection of arm
"Probably infect bite" (duration) yrs. mos. 5 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

2. DID AN OPERATION PRECEDE DEATH? yes DATE OF June 16 - 29

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Symptoms & Autopsy
(Signed) J. C. Hoagwood M. D.

*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 San Antonio Tex DATE OF BURIAL June 27 29

20. UNDERTAKER R. V. Lindsey + Son ADDRESS City

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS AN IMPORTANT RECORD

