

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

Do not use this space.

27853

3545

1. PLACE OF DEATH

County Jackson
Township Rox
City Kansas City (No. 7542)

399

Registration District No. _____
Primary Registration District No. 1002

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

2. FULL NAME

Arnon G. French
(a) Residence. No. 7542 Harrison St. Ward _____
(Usual place of abode)

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. (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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 2, 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	83	4	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) Missouri

10. NAME OF FATHER John F. French

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

12. MAIDEN NAME OF MOTHER Martha Reavis

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

14. INFORMANT Sallie A. French
(Address) 7542 Harrison

15. FILED 8/19/29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from July 1st. 29 to Aug 18 29 that I last saw him alive on Aug 18 29 and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

① Chronic Coma
② Mitral Insufficiency
③ Oedema of Lungs
(duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTOR (SECONDARY) Chronic Nephritis Interstitial
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHERE WAS AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab.

(Signature) Eugene Barbara

(Address) 8110 27th 531 North St

*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 Elmwood DATE OF BURIAL Aug 20 1929

20. UNDERTAKER Wynnewood Sons ADDRESS K.C. Mo

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 A PUBLIC RECORD

531⁰ Argyle Bldg.

Vic. 8530

2-ls.