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

Do not use this space.

37066

File No.
Registered No. 4.J.60

1. PLACE OF DEATH
County: Jackson
Township: Kansas City
City: Kansas City (No. St. Mary's Hospital St. Ward)
Registration District No. 399
Primary Registration District No. 1002

2. FULL NAME John V. Claudel (Claudel)
(a) Residence. No. 415 West 14 St., 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) September 13 1859

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	1	19	

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):
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Frank Claudel
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) France
12. MAIDEN NAME OF MOTHER Madeline Cooper
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Germany

14. INFORMANT Martin F. Sweat
(Address) Kirwin Kansas

15. FILED 11/3, 1929 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929, to Nov. 2, 1929, that I last saw him alive on Nov. 2, 1929, and that death occurred, on the date stated above, at 7:40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1. Chronic interstitial nephritis
2. Uremia (duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) bronchio pneumonia (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? do not know
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical, laboratory
(Signed) Jesse R. Haley M. D
Nov 3, 1929 (Address) 1002 Medical Arts 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: Mt St Marys Cemetery — DATE OF BURIAL: Nov 1929
20. UNDERTAKER: John J. Sheehan — ADDRESS: K.C. Mo

237
2
7
10

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A [illegible] FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County..... Registration District No. 399 File No. .....

Township..... Primary Registration District No. 1000 Registered No. 4530

City K. City (No. ..... St. ..... Ward)

2. FULL NAME John S. Claudel

(a) Residence. No. ..... St., ... 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	S

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
(Address)

15. FILED 11/3, 19 29 M. M. Crowley REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 1929

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY (SECONDARY).....

..... (duration) .....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)....., M. D.

, 19 (Address)

*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 | DATE OF BURIAL Nov 4, 1929

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

S-37066