

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

Do not use this space.
37407
4887

1. PLACE OF DEATH

County Jackson Registration District No. 392
Township KAY Primary Registration District No. 1002
City Kansas City (No. 1905 Agnes St. _____ Ward)

File No. _____

Registered No. _____

2. FULL NAME Mrs. Claudia Sportsman

(a) Residence. No. 1905 Agnes St. 11 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-26 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:

Chronic myocarditis
2 1/2 - 3 (duration) yrs. mos. ds.
9 1/2 - 10 (duration) yrs. mos. ds.
Tuberculosis
CONTRIBUTORY (SECONDARY) _____
(duration) yrs. mos. ds.

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

Fred Sportsman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 15, 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
59 2 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy

(Signed) Harvey M. Hayes M. D.

11/26 1929 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bates City, Mo. DATE OF BURIAL Nov. 27 29/29

20. UNDERTAKER R. V. Lindsey & Sons, Inc. ADDRESS Kans City Mo

14. INFORMANT Coroner's Record (Address) K. 6. Mo

15. FILED 11/27 1929 M. M. Crowe REGISTRAR
asil

PARENTS

10. NAME OF FATHER Hugh Schrimsher

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

12. MAIDEN NAME OF MOTHER Catherine Scott

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

Exact statement of OCCUPATION is very important. Do not leave blank. Do not write "none" unless property classified.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 399 File No.
 Township..... Primary Registration District No. 1002 Registered No. 4877
 City J. City (No.) St. Ward.....

2. FULL NAME

Mrs. Claudia Spontoman
 (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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/26 1929

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

17. I HEREBY CERTIFY That I attended deceased from..... 19..... to..... 19..... that I last saw him alive on..... 19....., and that death occurred, on the date stated above, at..... m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

Chronic Myocarditis
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Tuberculosis
Pulmonary (duration) yrs. mos. ds.

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.....

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.

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

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 11/27, 1929 M. M. Grove REGISTRAR
Wes

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED. Exact statement of OCCUPATION is required. CAUTION: BIRTH IN plain terms, 89 U. S. C. 1001 may be properly classified.

SUPPLEMENTARY

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