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

Do not use this space.

1163

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1022 — Registered No. 151
City Kansas City (No. 622 Troost, ave. St. Ward)

2. FULL NAME Sonie Olden
(a) Residence. No. 622 Troost St., 1 Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Married
6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 23. 189
7. AGE: Years 40 — Months 5 — Days 16 — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teamster
(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): Mo
PARENTS
10. NAME OF FATHER: Adam Olden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Fannie Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky.
14. INFORMANT (Address): Eva White
15. FILED Jan 12, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 9th 1930
17. I HEREBY CERTIFY, That I attended deceased from Nov. 4th to ~~January 9~~, 1929, to January 9th, 1930 that I last saw h. 4 P.M. alive on January 9, 1930, and that death occurred, on the date stated above, at 7-45 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
08
13 1-01 A
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY): Myocarditis
(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at home
DID AN OPERATION PRECEDE DEATH? ~~Nothing~~ DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? by Pneumoscopic
(Signed) Dr. D. J. Hunt, M.D.
1/10, 1930 (Address) 728 Tracy ave

*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: Maple Hill Cemetery — DATE OF BURIAL: Jan. 13 1930
20. UNDERTAKER: West Appleton & Jones — ADDRESS: 1600 E. 19 st.

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.