

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

Do not use this space.

19561

1. PLACE OF DEATH **U.S.V.Hosp.**

399

County **Jackson**

Registration District No.

Township *Kaw*

Primary Registration District No. **1002**

City **Kansas City, Mo.**

(No. *U.S.V. Hospital*)

File No. *2531*

Registered No. *2531*

St. _____ Ward _____

2. FULL NAME **COLE, Bob**

C-207 438 WOE

(a) Residence. No. **4202 Harrison** St. **6** Ward. **Sgt. 1/c Med. Dept.**
(Usual place of abode) **Kansas City, Mo.**

(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) Married
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mrs. Mildred Cole**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 11, 1884**

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	45	9	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **None**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS	10. NAME OF FATHER Unknown
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
	12. MAIDEN NAME OF MOTHER Barbara Harris
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT **Mrs. Mildred Cole (wife)**
(Address) **4200 Harrison, K.C. Mo.**

15. FILED *6/20 30 M. Box 557* REGISTRAR *Arar*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 19 1930**

17. I HEREBY CERTIFY, That I attended deceased from **May 20**, 19**30**, to **June 19**, 19**30**, that I last saw him, alive on **June 19**, 19**30**, and that death occurred, on the date stated above, at **12:40 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis of the Insane.

83
_____ (duration) _____ yrs. _____ mos. _____ ds.
Unknown

CONTRIBUTORY (SECONDARY) *70*
_____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
Unknown
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Neurological & Serological**

W.E. Chambers, M.D.
W.E. Chambers, Medical Officer in Charge
U.S.V. Hospital, Kansas City, Mo.

*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 **National Military Home Leavenworth, Kansas** DATE OF BURIAL **6/21/30**

20. UNDERTAKER **Melody McGilley Funeral Home** 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 OUTLINE

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31

