

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

Do not use this space.

23109

1. PLACE OF DEATH

County Jackson Registration District No. 333

Township Kans Priority Registration District No. _____

City Kansas City (No. St. Landers Hospital)

File No. _____

Registered No. 3103

St. _____ Ward _____

2. FULL NAME

(a) Residence No. 418 West 10th St. W.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred - yrs. 7 mos. 1 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)

Divorced

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

Frances Bailey

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

Sept 10 - 1865

7. AGE

YEARS 64

MONTHS 10

DAYS 11

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

Barber

(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

no record.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

no record.

12. MAIDEN NAME OF MOTHER

no record.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

no record.

14. INFORMANT

(Address)

John K. Bailey
3831 Central

15. FILED

7/28, 1930

M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 27 - 1930

17. HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 27, 1930 that I last saw him alive on July 26, 1930, and that death occurred, on the date stated above, at 1:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

93C

71B

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

CONTRIBUTORY (SECONDARY)

Anemia

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

at Home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

physical

(Signed)

Dr. H. C. Peuce, M. D.

7/27, 1930

(Address) W. Cor 27 St. Prospect

*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

Harrisonville Mo. July 29, 1930

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster 918 Brodley

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.

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