

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

Do not use this space.

19628

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City (No. St. Lukes Hospital)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 2335 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Spring Hill St. Kans Ward. _____

(Usual place of abode) _____ (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 F 4. COLOR OR RACE W 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) _____

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
12 _____

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School Child
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spring Hill Kans

FATHER 13. NAME B. H. Newton

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spring Hill Kans

MOTHER 15. MAIDEN NAME Gladis Young

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Meru, Ind. Kans

17. INFORMANT (ADDRESS) Mrs. Ethel Thomas 3811 Wyanette St. C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Spring Hill Kans DATE June 4, 1933

19. UNDERTAKER (ADDRESS) P. O. Cronin Spring Hill Kans

20. FILED June 4, 1933 M. M. Cronin
Regist. _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 4, 1933

22. I HEREBY CERTIFY, That I attended deceased from 5-9, 1933 to 6-4, 1933

I last saw her alive on June - 3rd, 1933. Death is said to have occurred on the date stated above, at 3:00 a.m.

The principal cause of death and related causes of importance were as follows:

Streptococcus meningitis Date of onset _____

Other contributory causes of importance:

measles
ptiasis
mastoiditis acute

Name of operation maxillary Date of 5-11-33

What test confirmed diagnosis? negative Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) Jason Nelson, M. D.

(Address) 1730 W. Kelly Kansas City, 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.

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The Board of Directors of the University of California, San Diego, met on May 15, 1975, to discuss the annual report of the Board of Directors of the University of California, San Diego, for the year 1974-75. The Board of Directors of the University of California, San Diego, is composed of the following members:

Chairman: [Name]

Members: [List of names]

The Board of Directors of the University of California, San Diego, discussed the annual report of the Board of Directors of the University of California, San Diego, for the year 1974-75. The Board of Directors of the University of California, San Diego, discussed the annual report of the Board of Directors of the University of California, San Diego, for the year 1974-75. The Board of Directors of the University of California, San Diego, discussed the annual report of the Board of Directors of the University of California, San Diego, for the year 1974-75.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township _____
City Hannas City (No. _____)

Registration District No. 399
Primary Registration District No. 1402

File No. _____
Registered No. 2385
St. _____ Ward _____

2. FULL NAME

Paul E. Gorton

(a) Residence, No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 9, 1920

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
12 8 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 6/4 1933 M. M. Grove Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 4, 1933

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the _____ stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) _____, M. D.
(Address) _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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