

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

Do not use this space.

JAN 28 1935

399
2002

43215

1. PLACE OF DEATH

County Jackson Registration District No. 2002
 Township Kaw Primary Registration District No. _____
 City Kansas City Mo (No. Topping = Spadine) St. _____ Ward _____

2. FULL NAME

Mrs Josephine Delgado
 (a) Residence, No. Topping - Spadine St. Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Mex 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Jose Maria Delgado

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 11 26

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 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) Mexico

FATHER
 13. NAME Diego Rosales
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mexico

MOTHER
 15. MAIDEN NAME Monica Campos
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mexico

17. INFORMANT Necario Delgado
 (ADDRESS) Topping - Spadine

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys Cent DATE 12-29-34

19. UNDERTAKER Peter B. Lopatina
 (ADDRESS) 236 Campbell St. K.C. Mo

20. FILED 12.28.34 M.M. Crow Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/27/34
 22. I HEREBY CERTIFY that I attended deceased from _____ to _____, 19____
 I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above _____.

The principal cause of death and related causes of importance were as follows:
Chronic Pulmonary Date of onset _____
tuberculosis

Other contributory causes of importance: No

Name of operation _____ Date of _____
 What test confirmed diagnosis Autopsy there an autopsy? Yes

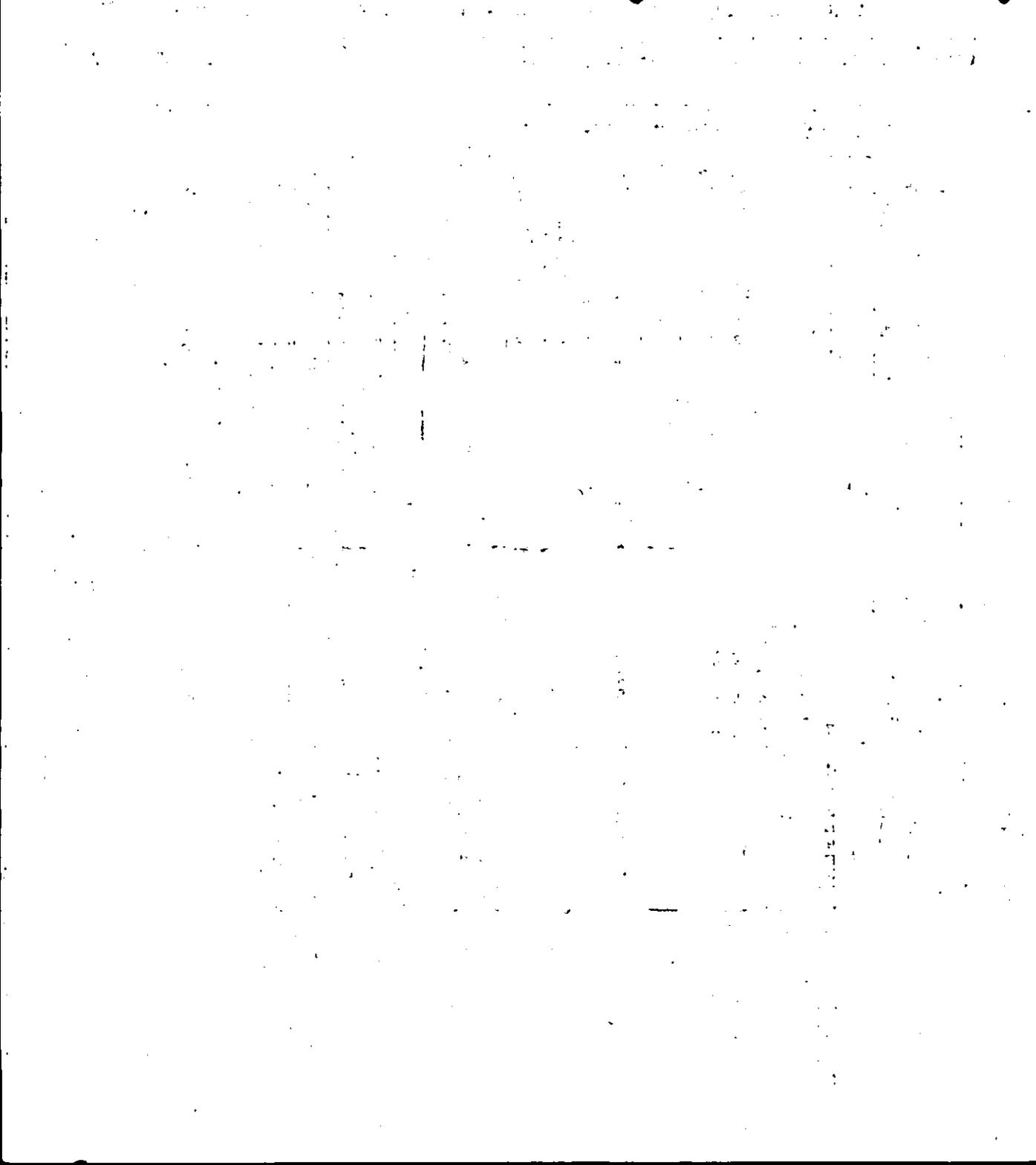
23. If death was due to external causes (violence), list in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury, in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) [Signature], M. D.
 (Address) [Address]

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.



**MISSOURI STATE BOARD OF HEALTH
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 (No. St. Ward)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 5601

2. FULL NAME

(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

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) 1-1-1896

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

38

11

26

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 1/28 1934 M. M. Cerow Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 27, 1934

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19.....

I last saw live on, 19..... Death is said

to have occurred on the date 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.

JAN 24 1935

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