

NOV 21 1938

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

34547  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Blue Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. R. E. T. D. Hosp. Registered No. 3883  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 625 Ward Passages  
2828 Cherry St. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
 4. COLOR OR RACE Amer  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1 1905  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
32 11 24  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. metal worker  
 9. Industry or business in which work was done, as 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) Springfield Missouri

13. NAME William Passous

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

15. MAIDEN NAME Florence Inman

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

17. INFORMANT R. E. T. D. Hosp. (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Cyark, Mo DATE Oct 6-38 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Pete B. Lageting  
12. S. Mo.

20. FILED Oct 5 1938 M. M. Grome Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25, 1938

22. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1938, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw him alive 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:

Pulmonary tuberculosis  
23 1/2  
 Date of onset 12-1-37  
 Other contributory causes of importance:

Name of operation None 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. Home

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) W. C. McLaughlin, M.D.  
 (Address) Jackson 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.

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**