

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

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. 33934
 Township Stear Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. 480) Wallace St. _____ Ward _____

2. FULL NAME

Bing O Lavin Larson
 (a) Residence. No. 480 Wallace 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 M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Computer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Sweden
 (STATE OR COUNTRY)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT (Address) Geo W Mc Cuel 480 Wallace

15. FILED 10-21-19 Edw Lomas REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24 1918

17. I HEREBY CERTIFY, That I attended deceased from 10-23-18 to 10-25-18, 1918 that I last saw h. _____ alive on _____ 1918, and that death occurred, on the date stated above, at 2 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Stomach

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

CONTRIBUTORY (SECONDARY) NO
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED CAUSE OF DEATH?
 (Signed) [Signature], M. D.
 (Address) 10-25-18 625 [Address]

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys DATE OF BURIAL 10-26 1918

20. UNDERTAKER Mc C L Foster ADDRESS Mc C L Foster

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.

