

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

29450

399

4053

1. PLACE OF DEATH

County Jackson
Township Kan.
City Kansas

Registration District No. 1002
Primary Registration District No. Old City Hospital

File No. 4053
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1513 Main 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1871

7. AGE YEARS 50 MONTHS _____ DAYS _____ IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Paris Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Jim Richardson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lucie Folkes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Mrs. Ida Porter
(Address) Kansas City, Mo.

15. FILED 11/21/21 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 20 1921

17. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1921, to Nov 20, 1921, that I last saw him alive on Nov 20, 1921, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Bronchitis
100 B.
100 B. (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic Endocarditis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE THE DISEASE CONTRACTED 99 B.
NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Tom J. Thompson, M. D.
11/21/21 (Address) Old General Hosp.

*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 Paris, Mo. DATE OF BURIAL 11/22 1921

20. UNDERTAKER Watkins Bros ADDRESS 1729 Lydia
7. B. Watkins

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.

