

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

18713

1. PLACE OF DEATH

County Baker Registration District No. 399 File No. 1878
 Township Raw Primary Registration District No. 1002 Registered No. _____
 City Kansas City Mo. (No. 1832 Baker) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1832 Baker 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19, 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 | 9 | 4

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Alfred Chambers

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

12. MAIDEN NAME OF MOTHER Sallie Jean

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

14. INFORMANT Minnie Riell
 (Address) 1832 Baker

15. FILED 124. 32 m. m. Brown
 19____ REGISTRAR Dep

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29 1922
 17. Deputy Coroner
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,
 that I last saw h. _____ alive on _____, 19____, and that
 death occurred, on the date stated above, at _____ 8:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131
97 (duration) yrs. mos. da.
 CONTRIBUTORY Arterio-sclerosis
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS THERE AN AUTOPSY no
 WHAT TEST CONFIRMED DIAGNOSIS History & Inspection
 (Signed) H. E. Mass, M. D.

*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 Forest Hill DATE OF BURIAL April 24 1922
 20. UNDERTAKER Mrs C. L. Foster ADDRESS H. C. 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.

THIS IS A PERMANENT RECORD

