

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

31568

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. 4513
 City Kansas City (No. 7438 Summit) St. _____ Ward _____

2. FULL NAME CALVIN B. HEWITT
 (a) Residence. No. 7438 Summit St. 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 22, 1848

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>74</u>	<u>8</u>	<u>7</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Dentist
 (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) Pa.

10. NAME OF FATHER John Hewitt

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

12. MAIDEN NAME OF MOTHER Moore

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

14. INFORMANT Mrs. C. B. Hewitt
 (Address) 7438 Summit, K.C. Mo.

15. FILED 17/1, 1922 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-30-22 1922

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Nov 29, 1922 that I last saw him alive on Nov 29, 1922, and that death occurred, on the date stated above, at 11-A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric Uleer
117A
132B (duration) 3 yrs. - mos. - ds.
 CONTRIBUTORY Uremia Passing (SECONDARY) (duration) yrs. mos. ds. 10

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) G. Albers, M. D.
17/1, 1922 (Address) 1025 Realto Kanawha

*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 <u>Linwood</u>	DATE OF BURIAL <u>12/2 1922</u>
20. UNDERTAKER <u>Shine & McClure Co.</u>	ADDRESS <u>924 Oak St.</u>

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.

