

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

Do not use this space.

✓ 1425

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399

Health District No. 1007

File No. 2 455
Registered No. 455
St. Mo. Ward

2. FULL NAME

(a) Residence. No. 1405 Vine St. St. Mo. 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. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (name) Carry Bates

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 25 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
46 ✓ - - - -

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) (STATE OR COUNTRY) Texas

10. NAME OF FATHER Leahguir Bates

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Carrie Bates
(Address) 1405 Vine

15. FILED 7/4 27 M. M. Crowe REGISTRAR
Asch

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-31-1927

17. I HEREBY CERTIFY, That I attended deceased from 1-19-27 to 1-31-1927, and that I last saw him alive on 1-31-1927, and that death occurred, on the date stated above, at 7 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Phthisis
2311 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. M. Smith, M. D.
5/2 1927 (Address) Old City Hospital

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leadmoor DATE OF BURIAL 2-4 1927

20. UNDERTAKER N. B. Moore ADDRESS 1820 E. 15th

WRITE PLAINLY, WITH UNIFORMITY. 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 496

City Kans. City (No.)

St.

Ward)

2. FULL NAME Lee Bates

(a) Residence. No.

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 B.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 25 - 1879

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

day, ... hrs.

or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

19

24 27 M. M. Browne
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1927

17.

I HEREBY CERTIFY That I attended deceased from

18.

to

19.

that I last saw him alive on

19.

death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

M. D.

, 19 (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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

5-1485