

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

Do not use this space.

4819

1. PLACE OF DEATH

County Jackson
Township KAW
City Kansas City (No. 5620 Forest)

Registration District No. 399
Primary Registration District No. 100x

File No. _____
Registered No. 614
St. _____ Ward _____

2. FULL NAME Lewis T. Herndon.

(a) Residence. No. 5620 Forest St. _____ Ward. _____
(Usual place of abode)

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. (If nonresident give city or town and State)

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 Herndon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 11, 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 5 0

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Barbourville, e.
(STATE OR COUNTRY) Ky.

10. NAME OF FATHER James H. Herndon

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

12. MAIDEN NAME OF MOTHER Katrinne Tye

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

14. INFORMANT Mrs. Kate Herndon
(Address) 5620 Forest

15. FILED 7/13 27 19 27 M. M. Crawley REGISTRAR
Acad-

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 11 1927

17. I HEREBY CERTIFY, That I attended deceased from 2/7/27 to 2/11/27 that I last saw him alive on 2/11/27, 1927, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

94A Acute Pectonis

93917

CONTRIBUTORY (SECONDARY)

chronic myocarditis (duration) yrs. mos. 4 da.
hypertension (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) Albert Florian, M.D.

2-12, 1927 (Address) 420 Chambers Bldg

*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 Lexington, Mo. DATE OF BURIAL 2/13/27 19

20. UNDERTAKER Whitney Sons ADDRESS city

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.

