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

Do not use this space.

4972

1. PLACE OF DEATH

County: Jackson Registration District No. 399

Township: Kansas Primary Registration District No.

City: Kansas City, Mo. (No. Old City Hospital St. Ward)

File No.

Registered No. 700

2. FULL NAME: Woolridge, Harrison

(a) Residence. No. 914 Chestnut 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: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Susan Woolridge

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Years 54; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Odd Jobs
(c) Name of employer: City

9. BIRTHPLACE (CITY OR TOWN): Cooper County
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: John Woolridge

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

12. MAIDEN NAME OF MOTHER: Dorothy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): West Virginia
(STATE OR COUNTRY)

14. INFORMANT: Mrs Ocie Robinson
(Address): 1027 Charlotte

15. FILED: 2/12, 1927 Wm. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 14 1927.

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1927, to Feb 14, 1927, that I last saw him alive on Feb 14, 1927, and that death occurred, on the date stated above, at 4:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis 8 2 1 9 3 8

Duel pf (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): General Pneumonia - Lucia

Duel pf (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Spinal Fluid Wass

(Signed) H. W. Smith, M. D

2/15, 1927 (Address) Old City Hosp. Kans City, Mo

*State the DISEASE CAUSING DEATH, or if 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: Richmond Cemetery — DATE OF BURIAL: 2-17 1927

20. UNDERTAKER: W. B. Fechner — 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.

[illegible] THIS IS A PERMANENT RECORD