

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

Do not use this space.

8051

1. PLACE OF DEATH

County Jackson Registration District No. 305 File No. _____
 Township Kear Primary Registration District No. _____ Registered No. 039
 City Kansas City (No. Kansas City Gen. Hosp.) St. _____ Ward _____

2. FULL NAME Inevett, Walter

(a) Residence. No. 541 Walnut St., _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1 1927

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

17. I HEREBY CERTIFY, That I attended deceased from 2-17 1927, to 3-1 1927, that I last saw him alive on 3-1 1927 and that death occurred, on the date stated above, at 7:10 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1, 1858

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
68 | 6 | | |

Adenoma of Prostate

8. OCCUPATION OF DECEASED Rooming House
 (a) Trade, profession, or particular kind of work Meat Keeper
 (b) General nature of industry, business, or establishment in which employed (or employer) Self
 (c) Name of employer _____

1.37 (duration) yrs. mos. ds.

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

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

10. NAME OF FATHER Frank C. Inevett

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

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Eliz Blackman

WHAT TEST CONFIRMED DIAGNOSIS? George P. Zea (Signed) _____ M. D. 3-1 1927 (Address) List Supt K.C. Gen. Hosp

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

*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.

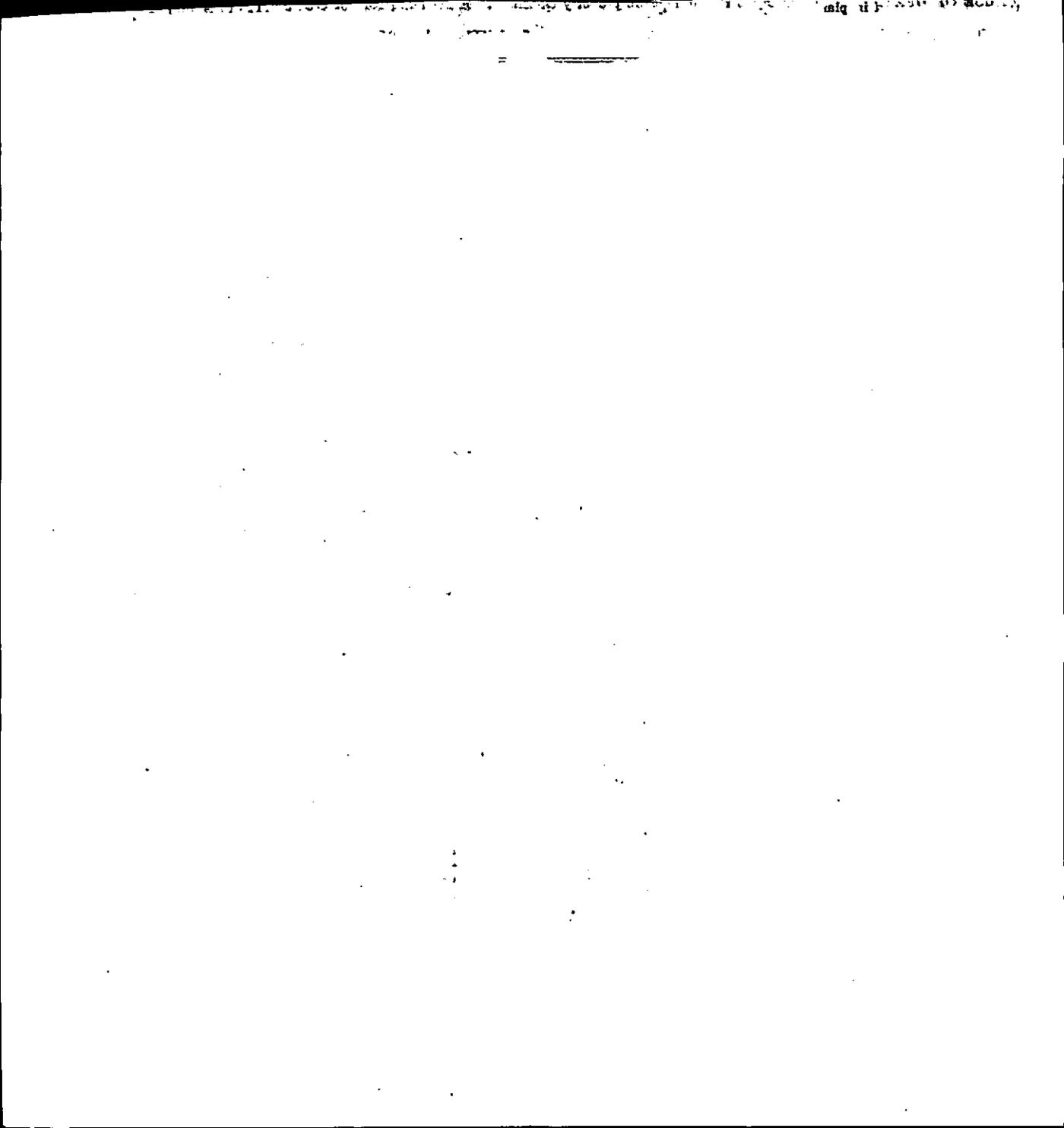
14. INFORMANT Record Clerk (Address) K. C. General Hosp

19. PLACE OF BURIAL, CREMATION, OR REMOVAL North Springs La. DATE OF BURIAL March 19-27

15. FILED 3/2 1927 M. M. Crowe REGISTRAR West

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. C. Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township _____ Primary Registration District No. 1007 Registered No. 899
 City N. City (No. _____) St. _____ Ward _____

2. FULL NAME

Brevett Walter
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar - 1 19 27

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

I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.

Adenoma of prostate (metastatic)

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 _____

CONTRIBUTORY (SECONDARY) 135

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

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

WAS THERE AN AUTOPSY: _____

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS: _____

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

(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.)

14. INFORMANT (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 3/2, 19 27 M. M. Browne REGISTRAR
Act

20. UNDERTAKER ADDRESS _____

THIS SHALL NOT RECEIVE A FEE FC UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

1508-5