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

Do not use this space.

File No. 10277

Registered No. 28865

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ..... (No. Barnes Hosp St. ..... Ward)

2. FULL NAME PHILLIP HOPKINS JANNY

(a) Residence. No. BAXTER SPRINGS St., 12 Ward. Baxter Springs Kan
(Usual place of abode) KANSAS. (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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 52			

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER John Janny

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not Known
(STATE OR COUNTRY)

14. INFORMANT Mrs. Wm Hoffman
(Address) Garrison Md.

15. FILED 3 1 1927 19 May C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 23 1927

17.

I HEREBY CERTIFY, That I attended deceased from 11-5, 1926, to 3-23, 1927 that I last saw h. S. O. alive on 3-25, 1927, and that death occurred, on the date stated above, at 9.45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1/14 Gastroenteritis
3/6 Carcinomas of Larynx
15 yrs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cellulitis of Leg + thigh due to Staphylococcus infection

(duration) ..... yrs. ..... mos. ..... ds.

Operation for an Abscess on leg from Cellulitis due to Staphylococcus Infection

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

DID AN OPERATION PRECEDE DEATH? yes. DATE OF .....

WAS THERE AN AUTOPSY? yes.

WHAT TEST CONFIRMED DIAGNOSIS? Operation

(Signed) C. H. Heidemann, M. D.

, 19 (Address) Barnes Hosp.

*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 Baltimore Md.

DATE OF BURIAL May 26 1927

20. UNDERTAKER Philander Craig

ADDRESS 1235 N Kingshighway

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.

WRITE PLAINLY, WITH UNFADING INK. WRITE THIS TO A PERMANENT RECORD