

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

Do not use this space.

11644

1. PLACE OF DEATH

County Jackson Registration District No. 189 File No. 1435
 Township Kan Primary Registration District No. 189 Registered No. 1435
 City Kansas City (No. K.C. General Hosp) St. Mo Ward

2. FULL NAME Halley Harry

(a) Residence No. 2116 1/2 Abash St. Ward
 (Usual place of abode)

Length of residence in city or town where death occurred 6 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 4 - 1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>40</u>	<u>1</u>	<u>4</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Furnace Repair
 (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) Iowa

10. NAME OF FATHER Bruce Halley

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

12. MAIDEN NAME OF MOTHER Clara Webb

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

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

15. FILED 4/5 27 1927 M.M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-4 1927
 17. 4

I HEREBY CERTIFY That I attended deceased from 2-9 27, 1927, to 4-4 27, 1927
 that I last saw him live on 4-4 27, 1927, and that death occurred, on the date stated above, at 8:35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
PS
 CONTRIBUTORY Parasitis - Malaria
 (SECONDARY) Sigmoidal abscess

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

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

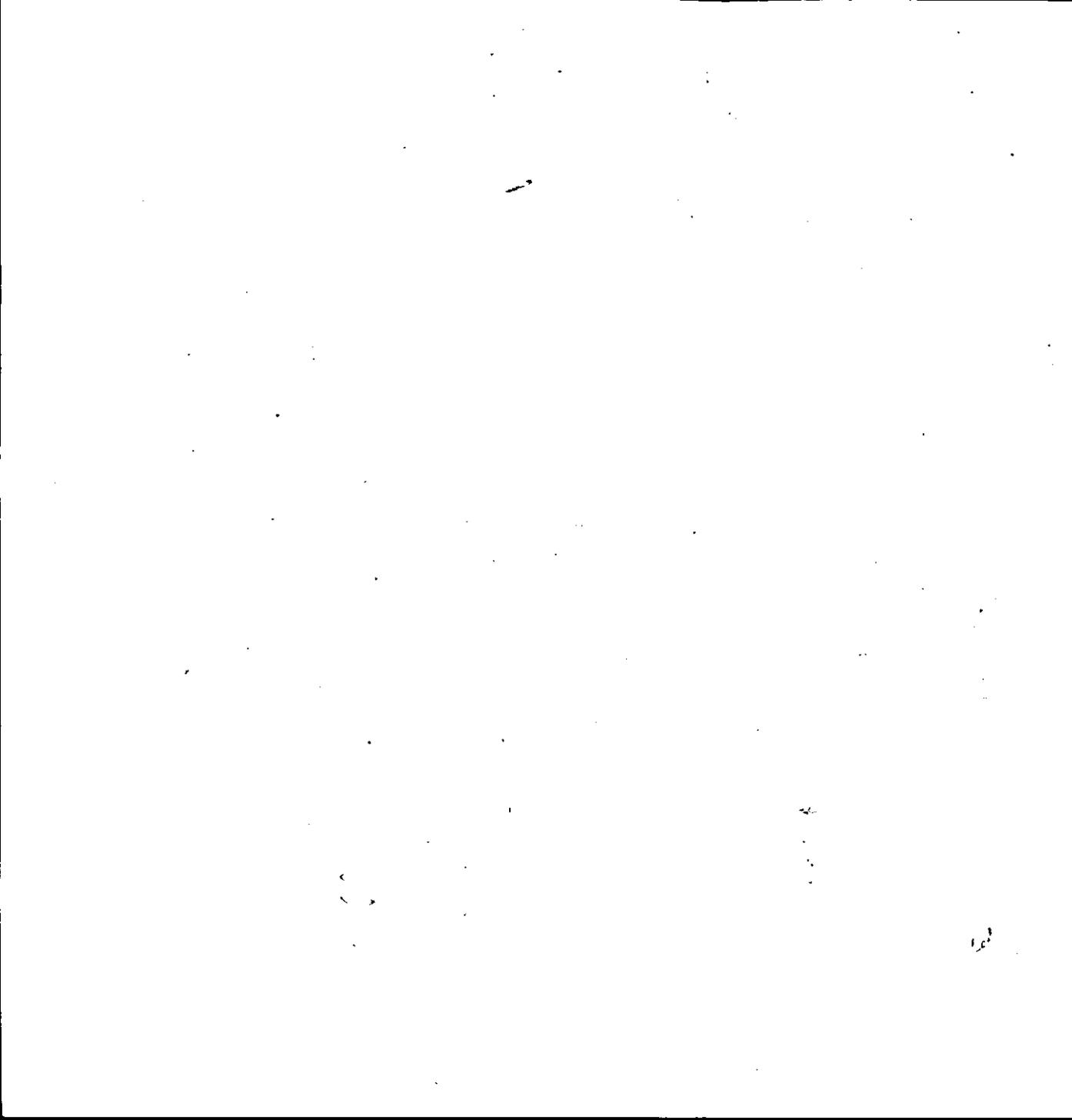
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Plent. Lab. Findings
 (Signed) P. O. Williams M. D.
 (Address) Dept 7 C. Genl 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 Memorial Park DATE OF BURIAL April 5 1927

20. UNDERTAKER O. H. Mart ADDRESS City



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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. 1435
 City Hans City (No.) St. Ward)

2. FULL NAME

Holley, Harry
 (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 W 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)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.

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)

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 4/5 27 AM M. Crowley REGISTRAR
best

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 4 1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septicemia
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) sepsis, malaria
schio-rectal abscess
 (duration) yrs. mos. ds.
streptococci infection
 (non-traumatic)

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) George R. Bee, M. D.
K. O. Ken Hoop, 19 (Address)

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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