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

Do not use this space.

11696

1. PLACE OF DEATH

County Jackson — Registration District No. 399

Township Kaw — Primary Registration District No. 1002

City Kaw City, MO (No. Old City Hospital St. Ward)

File No. [illegible]

Registered No. [illegible]

2. FULL NAME Richard Anderson

(a) Residence. No. 1715 Sycline 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: Negro

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) Unk 1875

7. AGE: 52 YEARS — MONTHS — DAYS — If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Unknown

(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): Unknown

PARENTS

10. NAME OF FATHER: Unknown

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT (Address): Old City Hospital

15. FILED 4/9, 1927 M M Crowe asst REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

2

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

17. I HEREBY CERTIFY, That I attended deceased from 3-2-, 1927, to 4-3-, 1927 that I last saw him alive on 4-3-, 1927, and that death occurred, on the date stated above, at 3:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

108 Chronic Myocarditis

9 SC

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Lobar Pneumonia (Unresolved)

(duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? NO. DATE OF

WAS THERE AN AUTOPSY? NO.

WHAT TEST CONFIRMED DIAGNOSIS?

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

4/4, 1927 (Address) Old City Hosp. K.C., MO

*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: Leeds Forum — DATE OF BURIAL: 4/11 1927

20. UNDERTAKER: West, Uppleton & Jones — ADDRESS: 1600 E. 19th

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] STATEMENT RECORD