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

Do not use this space.

11704

File No. 8-390

Registered No. 1550

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399

Township: 15 and — Primary Registration District No.: 1003

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

2. FULL NAME: Henry Sanders

(a) Residence. No. 2031 Holmes St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 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: Negro

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug - 16 - 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	7	15	

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): Labor

(c) Name of employer:

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

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: Old City Hospital
(Address): Kansas City Mo

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4 - 1 1927

17. I HEREBY CERTIFY, That I attended deceased from 3-25, 1927, to 4-1, 1927, that I last saw h. alive on 4-1, 1927, and that death occurred, on the date stated above, at 5 20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Cardiac Asthma

(duration) yrs. mos. ds.

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? Clinical & laboratory

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

4/2, 1927 (Address) Old City Hospital 22nd & 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, CREATION, OR REMOVAL: Lee's Summit

DATE OF BURIAL: 4/1, 1927

20. UNDERTAKER: Weil, Appleton & Jones

ADDRESS: 1600 E 19th St

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.

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