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

Do not use this space.

~~11822~~

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 1618
Township Kaw — Primary Registration District No. 1002 — Registered No.
City K C (No. 2334 Monitor St. St. Ward)

2. FULL NAME Jaun Peres
(a) Residence. No. 3015 Sunnette 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: Ma
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 1869

7. AGE: 58 Years ✓ Months 7 Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lab.
(b) General nature of industry, business, or establishment in which employed (or employer) Mo Pac RR
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Leon Adamas
(STATE OR COUNTRY) Mexico

PARENTS
10. NAME OF FATHER Tomaso Peres
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Leon Adamas
(STATE OR COUNTRY) Mexico
12. MAIDEN NAME OF MOTHER Ugliano Pampa
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Leon Adamas
(STATE OR COUNTRY) Mexico

14. INFORMANT Augustina Peres
(Address) 3015 Sunnette

15. FILED 4/18, 1927 M. M. Crowe REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-14-27

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
131
93C (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Pancrhysiotis
Nephritis (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1290
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
4/14/27 (Signed) [signature], M. D
19 (Address) Deputy Coroner

*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: Mt St Marys — DATE OF BURIAL: 4/18 1927

20. UNDERTAKER: [signature] — ADDRESS: KC.

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 ..... Registration District No. 399 File No. 11822

Township ..... Primary Registration District No. 1002 Registered No. 1618

City Kans City (No. ....., ... St. ..... Ward)

2. FULL NAME Jason Peres

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 2nd 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	58	7	1	

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)

PARENTS
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 4/18, 1927 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 14 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY .....
(SECONDARY)

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

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) ....., 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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