

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

Do not use this space.

15073

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 1002
 City Kansas City (No. 53rd Highland) St. Highland (Ward)

File No. 1927
 Registered No. 1927

2. FULL NAME

Charlie Stephens
 (a) Residence No. Home of the aged St. Highland Ward. 53rd
 (Usual place of abode) 53rd Highland (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? 0 yrs. 0 mos. 0 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 None

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 1855

7. AGE YEARS 72 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) 131 93
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

10. NAME OF FATHER Not known

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

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT Little Sisters of the Poor
 (Address) 53rd Highland

15. FILED May 11 1927 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1927

17. I HEREBY CERTIFY, That I attended deceased from April 1 1927 to May 9 1927 that I last saw him alive on May 9 1927, and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis & nephritis, chronic renal (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 1290 (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? Physical Exam
 (Signed) A. Arch-Ronit, M. D.

5/11 1927 (Address) 1034 Apple St
 *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

Calvary Cemetery 5/11 1927

20. UNDERTAKER ADDRESS Durk & Robin 20th Leewood

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.

THIS IS A PERMANENT RECORD

