

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

Do not use this space.

15135

1. PLACE OF DEATH

County Jackson
Township Stear
City N.E. 2nd

Registration District No. 399
County Registrar District No. 1002
St. Marys Hospital

File No. _____
Registered No. 2003 St. _____ Ward

2. FULL NAME

(a) Residence. No. 2018 Cleveland St., _____ Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 5 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 Opal Kohn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 4 - 1900

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>26</u>	<u>8</u>	<u>10</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer Mo Pacific Shop.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Minnesota

PARENTS

10. NAME OF FATHER Mike Kohn

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

12. MAIDEN NAME OF MOTHER Emma Sapp

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

14. INFORMANT Mrs Opal Kohn
(Address) 2018 Cleveland

15. May 16, 27 M. M. Conner
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/14 1927

17. I HEREBY CERTIFY, That I attended deceased from 5/10 1927, to 5/14 1927, that I last saw him alive on 5/14 1927, and that death occurred, on the date stated above, at 5 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrenous Appendicitis

117 (duration) _____ yrs. _____ mos. 5 ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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

1 DID AN OPERATION PRECEDE DEATH: yes DATE 5/10/27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) J E Coates M. D.
(Address) 1001 Chambers Bldg KC 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 Memorial Park DATE OF BURIAL May 19 27
20. UNDERTAKER Mrs E L Forster ADDRESS 918 Brooklyn

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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