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

Do not use this space.

21314

File No. 2656

Registered No.

1. PLACE OF DEATH

County Jackson — Registration District No.

Township Kaw — Primary Registration District No.

City Kansas City (No. 1328 Broadway St. Ward)

2. FULL NAME Newl S Wight

(a) Residence. No. 1328 Broadway St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov - 18 - 1857

7. AGE: Years 69 | Months 7 | Days 13 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Furniture Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

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

PARENTS

10. NAME OF FATHER: No Record
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): No Record
12. MAIDEN NAME OF MOTHER: No Record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): No Record

14. INFORMANT: Walter Vail
(Address) 6033 Harrison

15. FILED 7-2 1927 M M Crowe REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1927, to July 1, 1927, that I last saw him alive on July 1, 1927, and that death occurred, on the date stated above, at 4:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy.
89
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Angina pectoris
(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? —

(Signed) H. C. Long M. D
7/2, 1927 (Address) 520 Commerce Bld

*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: Forest Hill — DATE OF BURIAL: July 5 1927

20. UNDERTAKER: Mrs. C L Forster — ADDRESS: 918 Brooklyn

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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