

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

Do not use this space.

21504

1. PLACE OF DEATH

County Jackson
Township Haw
City Kansas City (No. K.C. Genl Hosp.)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2852
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 548 Main 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

male | White | Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 8 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.

42 | 5 | 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employee) _____
(c) Name of employer _____

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

10. NAME OF FATHER Israel Martin

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

12. MAIDEN NAME OF MOTHER Rebecca Martin

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

14. INFORMANT Reverend Clerk
(Address) K.C. Genl Hosp.

15. July 19 27 M. M. Lesuire
REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-15 1927

17. I HEREBY CERTIFY, That I attended deceased from 6-27, 1927, to 7-15, 1927, that I last saw him alive on 7-15, 1927, and that death occurred, on the date stated above, at 3:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubo-pneumonia
76 83
76 108
(duration) yrs. mos. da.
CONTRIBUTORY Lobar Pneumonia
(SECONDARY) (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
7-15 (Signed) George O. Lee, M. D.
Address General Hosp. K.C. 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 Calvary Cemetery DATE OF BURIAL 7-19 1927

20. UNDERTAKER O. V. Mast ADDRESS 1915 E 15

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

