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

Do not use this space.

21516

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 2864

City Kansas City (No. Research Hospital St. Ward)

2. FULL NAME JAMES HENRY PERRY

(a) Residence. No. 711 Westport Avenue St., 7 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12, 1846

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	81	2	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired 139
(b) General nature of industry, business, or establishment in which employed (or employer) Stockman 139A 131B
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT J. W. Perry
(Address) 1217 Santa Fe Road

15. FILED 7/20, 1927 M. M. Crowe REGISTRAR
Asst

4

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-16, 1927, to 7-19, 1927 that I last saw him alive on 7-19, 1927, and that death occurred, on the date stated above, at 11:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Prostatic Obstruction with Pyelonephritis

35

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Anemia and Uremia

(duration) III yrs. Seven mos. II 2 ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) Wilson A. Myers, M.D.

7/20, 1927 (Address) 815 Shukert Bldg

*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
Mt. Washington Cem	7-21 1927
20. UNDERTAKER	**ADDRESS**
Stiles & McClure	924 Oak

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.

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

815 Shukert Bldg