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

Do not use this space.

24390

1. PLACE OF DEATH U.S.V.Hosp. #67

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

Township Kaw — Primary Registration District No. 1002 — Registered No. 3077

City Kansas City, Mo. (No. U. S. Veterans Hospital St. Ward)

2. FULL NAME GOTT, William H — C-SPBW

(a) Residence: No. 19th & Kansas Ave., St., Ward. Co E 16th Reg. Cav. Mo. Vol.

(Usual place of abode) Kansas City, Mo. (If nonresident give city or town and State)

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): Widowed.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-10-1843

7. AGE: Years 83 | Months 10 | Days 2 | 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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Arkansas

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 Hospital Records

(Address) K. C. Mo

15. FILED 8/15, 19 27 M. M. Crowe

Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 12 1927

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1927 to Aug 12, 1927 that I last saw him alive on Aug 12, 1927, and that death occurred, on the date stated above, at 5:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

V.H.D. Mitral Stenosis & Chr. Endocarditis.

Probably several years. (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Bronchial Pneumonia hypostatic R & L Bases Posterior. (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam. & X-ray

(Signed) E. J. Rose, M. D

(Address) U.S.V.H. #67 Kansas City, Mo. E. J. ROSE, Medical Officer in Charge

*State the DISEASE CAUSING DEATH, or if death 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: Aug 15th 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.