

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

Do not use this space.

24521

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township St. Louis Primary Registration District No. _____
City Kansas City (No. 6001) Cherry St. _____ (Ward)

File No. _____
Registered No. 83250
St. _____ (Ward)

2. FULL NAME

(a) Residence. No. 6001 Cherry St., 8 Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh 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) Apr. 7 1856

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
71 | 4 | 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
(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) Unknown

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 Mrs S. T. Henderson (Address) 6001 Cherry

15. FILED 8-27-27 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 26 1927

17. I HEREBY CERTIFY, That I attended deceased from April 1925, to Aug. 26, 1927
that I last saw h.l.m. alive on Aug. 26, 1927, and that death occurred, on the date stated above, at 6:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

46E Cancer of Gall Bladder
(duration) yrs. 9 mos. da.

CONTRIBUTORY (SECONDARY) NONE
(duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) F. B. Wallace, M. D.

927, 1927 (Address) 713 Walltop Bldg. 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 St. Louis, Mo. DATE OF BURIAL 8-27 1927

20. UNDERTAKER L. H. Newcomer, St. Louis, Mo. ADDRESS _____

WRITE FAIRLY, 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.

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED
DATE 06-6-83 BY
713 J. A. [unclear]
12-4: [unclear]