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

Do not use this space.

024524

File No. [illegible]

Registered No. [illegible]

1. PLACE OF DEATH

County Jackson — Registration District No.

Township Kaw — Primary Registration District No.

City Kansas City (No. St Luke's Hospital St. Ward)

2. FULL NAME Melvin Large

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

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: wh

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22, 1922

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
5	0	5	

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) Weston
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Ernest Large

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

12. MAIDEN NAME OF MOTHER Elsie Blackettler

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

14. INFORMANT Ernest Large
(Address) Weston Mo.

15. FILED 8-27, 1927 M M Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Aug. 27, 1927, that I last saw him alive on Aug 27, 1927, and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tetanus

22

185 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Punctured Wound of left foot (duration) yrs. mos. 21 ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) H. V. Baughnon, M. D

8/27, 1927 (Address) 906 Medical Arts

*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: Weston, Mo.

DATE OF BURIAL: Aug. 27 1927

20. UNDERTAKER: A. W. Newcomer's Sons

ADDRESS: K. C. Mo.

N. B. Every item of information should be carefully supplied. AGE EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important.

B.P. Inc.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.:
Township: — Primary Registration District No.: 1002 — Registered No.: 33713
City: K. City (No. ; St. Ward)

2. FULL NAME: Melvin Large

(a) Residence. No. 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

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

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

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 19 27

17. I HEREBY CERTIFY, That I attended deceased from 19 to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tetanus
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Punctured wound of left foot
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Stepped on
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? Dan Ford
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D.
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

THIS IS A PERMANENT RECORD

SHALL NOT RECEIVED BY LAW A FEE FOR CERTIFICATE

S-24526