

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

Do not use this space.

24536

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City Mo. (No. St. Joseph Hospital)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 3325 St. Ward)

2. FULL NAME

Theodore Milton Kinnard

(a) Residence, No. 1417 Forest St., 2 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. 2 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June-8-1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 2 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Decorator
(b) General nature of industry, business, or establishment in which employed (or employer) P. Evens
(c) Name of employer Res. 5024 Park

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

PARENTS

10. NAME OF FATHER Theodore Kinnard

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph, Mo

12. MAIDEN NAME OF MOTHER Rebecca Sandford

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

14. INFORMANT Mrs. Ada Gracie Jefferson Highlands
(Address)

15. 8180027 M. M. Brown REGISTRAR
FILED 19.....

MEDICAL CERTIFICATE OF DEATH

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

17. Coroner
I HEREBY CERTIFY, That I attended deceased from
....., 19....., to 19....., 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental Traumatism
- Fall from ladder -
1867 Multiple injuries
1948 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 185 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) H. G. Moss, M. D.
8-26, 1927 (Address) Coroner

*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 Mt Washington Cem DATE OF BURIAL Aug-29 1927

20. UNDERTAKER A. P. Doehler ADDRESS 1415 E 15

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.

THIS IS A PERMANENT RECORD

