

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

Do not use this space.

27151

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Haw Primary Registration District No. _____ Registered No. 3405
 City Kennett, MO (No. R. 2, General Field) St. _____ Ward _____

2. FULL NAME

Dave Alfred
 (a) Residence. No. 1324 Harrison St. Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 6 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 W 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) Apr. 28th/1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
5 4 6 _____

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) Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Dave Jake

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

12. MAIDEN NAME OF MOTHER Laura Weddle

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

14. INFORMANT Record Clerk
 (Address) Kennett City Gen'l Hosp.

15. FILED 9/5, 1927 M.M. Corowe
 REGISTRAR acc

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-4 1927

17. I HEREBY CERTIFY, That I attended deceased from 9-3 1927, to 9-4 1927, that I last saw him alive on 9-4 1927, and that death occurred, on the date stated above, at 7:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis
12/1A
29 1/7 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) Appendicitis with perforation (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) George C. Fee, M. D.
9/5, 1927 (Address) General Hosp & C.M.

*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 Richmond Mo DATE OF BURIAL 9/5 27

20. UNDERTAKER O. Mast ADDRESS Rt 1 Box 45

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

