

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

Do not use this space.

27284

**1. PLACE OF DEATH**

County Jackson  
Township Raw  
City Kansas City (No. 431)

Registration District No. 1003  
Primary Registration District No. 711th

File No. \_\_\_\_\_  
Registered No. 3544  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. Kronaw Saskatchewan Canada  
(Usual place of abode)  
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7th 1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
44 | 10 | \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(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) Kansas

10. NAME OF FATHER Wm M McCall

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

12. MAIDEN NAME OF MOTHER Deliah Anderson

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

14. INFORMANT Dr. F.M. Plauer  
(Address) 12th Washington

15. FILED 9-15-27 HA McCreavey  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept - 14 1927

17. I HEREBY CERTIFY, That I attended deceased from 22 July, 1927, to 14 Sept, 1927.  
That I last saw him alive on 13-Sept-27, 1927, and that death occurred, on the date stated above, at 4-4-a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Endocarditis Chronic  
92A

(duration) 9 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTOR (SECONDARY) [Signature]  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRIBUTED? IF NOT AT PLACE OF DEATH his home.

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physial Examination  
(Signed) F.M. Plauer, M. D.

9/14-1927 (Address) 1119 Washington St  
\*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 Bonessard, Mo. DATE OF BURIAL Sept. 15 1927

20. UNDERTAKER A. H. Newe ADDRESS Missouri St. C. Mo.

K. 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 PERMANENT RECORD

12<sup>th</sup> ↓ 20: ...  
Vic 1114.  
10<sup>th</sup> on