

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

Do not use this space.

27309

**1. PLACE OF DEATH**

County Jackson  
Township Kear  
City Kansas City, Mo.

Registration District No. ....  
Primary Registration District No. ....

File No. ....  
Registered No. 3560  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. Detroit Mich. 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. ds. 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 Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 40

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Newspaper  
(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) Don't know

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Record at Hospital  
(Address) K.C. Mo

15. FILED 9-17-27 REGISTRAR West

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-16 19 27

17. I HEREBY CERTIFY, That I attended deceased from 8-16-27 19 27  
to 9-16 19 27  
that I last saw him alive on 9-15 19 27, and that death occurred, on the date stated above, at 4 Am. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
General peritonitis and  
profound sepsis from  
ruptured appendix  
(duration) yrs. mos. ds. 30  
CONTRIBUTORY acute suppurative  
(SECONDARY) appendicitis  
(duration) yrs. mos. ds. 3.0

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH. 1115

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 9-10-27  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Operation  
(Signed) Eugene Hamilton, M. D.  
9-16, 1927 (Address) Kansas City 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 DATE OF BURIAL  
Detroit Mich 7/17 19 27

20. UNDERTAKER ADDRESS  
O. Mast 1916 East 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.

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