

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

Do not use this space.

27335

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 3500
 Township Kear Primary Registration District No. 1100 Registered No. 3500
 City Kansas City, Mo. Mercy Hospital St. _____ Ward _____

2. FULL NAME Tom Baker

(a) Residence, No. 1675 W 43 St. 7 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. 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) Inf.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
16 days

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) General Hospital
 (STATE OR COUNTRY) KC Mo

10. NAME OF FATHER Wm. C. Cox

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

12. MAIDEN NAME OF MOTHER Lula Buckingham

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

14. INFORMANT Record at Hospital
 (Address) General Hospital

15. FILED 9/30 27 M. M. Crawley REGISTRAR
acc

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-18-1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Bronchitis
119 Acute Bronchopneumonia
107A
108A

(duration) yrs. mos. ds. 1
 CONTRIBUTORY (SECONDARY) Acute Enteritis
 (duration) yrs. mos. ds. 2

18. WHERE WAS DISEASE CONTRACTED 113 B
 IF NOT AT PLACE OF DEATH: _____

0 Did an operation precede death? No. DATE OF _____

Was there an autopsy? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Cross Inspection
9/19 (Signed) Edward Doyle M. D.

1927 (Address) Orl Hospital - RCK

*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. Hope DATE OF BURIAL 9-20 1927

20. UNDERTAKER D. V. Mast ADDRESS _____

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.

