

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

Do not use this space.

30285

1. PLACE OF DEATH

County Jackson
Township Ross
City Kans City Mo (No. St Lukes Hosp)

Registration District No. 399
Primary Registration District No. 1007

File No. _____
Registered No. 3790
St. _____ Ward _____

2. FULL NAME

W. F. Duvall
(a) Residence. No. Butler Mo St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Aris Duvall

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 21 - 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 8 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Banker
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Butler
(STATE OR COUNTRY) Mo

10. NAME OF FATHER W. F. Duvall

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

12. MAIDEN NAME OF MOTHER Jesse Childs

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

14. INFORMANT W F Duvall
(Address) Butler Mo

15. FILED 10/7 1927 M M Crowe
Ariss REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 7 1927

17. I HEREBY CERTIFY That I attended deceased from Oct 1, 1927, to Oct 7, 1927 (that I last saw h. _____ alive on Oct 7 5 p. 1927, and that death occurred, on the date stated above, at _____ m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumococci Meningitis
1048
7998

(duration) _____ yrs. _____ mos. 7 da.
CONTRIBUTORY Ethmoiditis & Sphenoiditis
(SECONDARY) (duration) 63 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? yes DATE OF 10/5-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Spinal Fluid Culture & Smears
(Signed) R. E. Jell, M. D.
10/7, 1927 (Address) 1100 Real & Bldg

*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

Butler - Mo Oct 7 1927

20. UNDERTAKER ADDRESS Shawnewomen's Lous F. C. Mo.

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Trans. City
City Trans. City (No.) St. Ward

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 3790

2. FULL NAME

William Leslie Ruvalle

(a) Residence. No. St. 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
DIVERCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 23 - 1899

7. AGE YEARS MONTHS DAYS If LESS than 1
4 28 8 14 day, hrs.
or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT
(Address)

15.

FILED 10/27 1927 M. M. Brown
REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from to 19

that I last saw h. on the 19

death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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), M. D.

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

W. R.—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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30285