

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

Do not use this space.

30356

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 3  
Township New Primary Registration District No. 197 Registered No. 3  
City Kansas City, Mo. Old City Hospital St.        Ward       

**2. FULL NAME**

(a) Residence. No. 620-6-6A St.        Ward.         
(Usual place of abode)  
Length of residence in city or town where death occurred 24 yrs. mos.        ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
47 — —

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work God Carrier  
(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) Arkansas

10. NAME OF FATHER Mose Weise

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

12. MAIDEN NAME OF MOTHER Marguerite - ?

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

14. INFORMANT (Address) Robert Record Old City Hospital

15. FILED 10/12/27 1927 M. M. Groves REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-9-1927

17. I HEREBY CERTIFY, That I attended deceased from 9-5-1927 to 10-9-1927  
that I last saw him alive on 10-9-1927, and that death occurred, on the date stated above, at 10:56 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Edema  
23H  
110B (duration)        yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Pleurisy with effusion  
Tuberculous (duration)        yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF       

WAS THERE AN AUTOPSY? No

WHAT TEST CONCERNED DIAGNOSIS? Clinical  
(Signed) Howard M. Smith, M. D.  
10/10, 1927 (Address) Old City Hospital

\*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 Maple Hill DATE OF BURIAL 10/13 1927

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Hyde

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.

DEPARTMENT RECORD

