

1228

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

Do not use this space.

32933

1. PLACE OF DEATH

County Carroll

Registration District No. 135

File No. _____

Township _____

Primary Registration District No. 3010

Registered No. 108

City Carrollton (No. _____)

St. _____ Ward _____

2. FULL NAME

Wm Kenneth White

(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. 2 mos. 16 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-5-1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. 2 16

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Carl White

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

12. MAIDEN NAME OF MOTHER Anna Martha Wilson

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

14. INFORMANT Winnie Marshall (Address) Carrollton, Mo

15. FILED 11-22-27 Mrs E E Farnham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-21 1927

I HEREBY CERTIFY, That I attended deceased from 11-21 1927, to 11-21 1927 that I last saw him alive on 11/21 1927 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchitis pneumonia
107A
(duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (SECONDARY)

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? _____

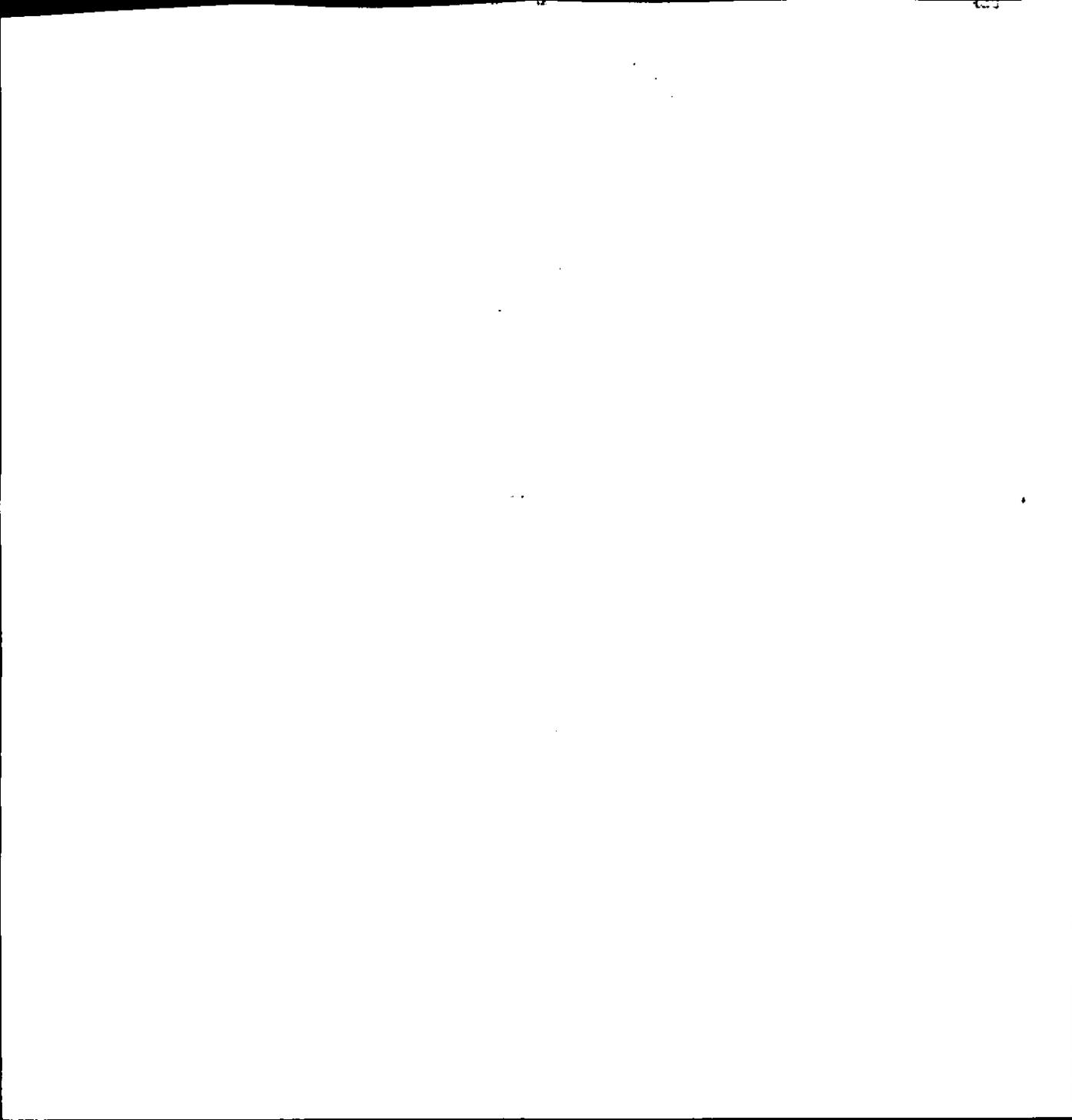
(Signed) E B Grover M. D.

11-22, 1927 (Address) Carrollton, 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 African Oak Hill DATE OF BURIAL 11-22-1927

20. UNDERTAKER Wilton Standley ADDRESS Carrollton Mo



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

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Carroll Registration District No. 135 File No. _____
 Township _____ Primary Registration District No. 3010 Registered No. 108
 City Carrollton (No. _____) St. _____ Ward _____

2. FULL NAME Wm Kenneth White

(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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-21-1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS
Primary Cause Pneumonia
 (duration) yrs. mos. ds. X

CONTRIBUTORY (SECONDARY) 1000
 (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.

14. INFORMANT _____ (Address) _____

15. FILED 11-22-27 Mrs. E. E. Jamham REGISTRAR

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

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

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

OF DEATH IN plain terms, so that it may be properly certified

S-32933