WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

Do not use this space.

36957

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 4780
Township Kaw — Primary Registration District No. 1002 — Registered No. 4780
City K. C. (No. St Joseph Hosp St. Ward)

2. FULL NAME Harrison Fell
(a) Residence. No. 3115 E 20th St., 11 Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 6 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: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 13th 1856

7. AGE: Years 71 — Months 8 — Days 5 — If LESS than 1 day, ... hrs. or ..... min.

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

PARENTS
10. NAME OF FATHER: Wm Fell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): England
12. MAIDEN NAME OF MOTHER: Elizabeth Harrison
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): England

14. INFORMANT (Address): Mayberry Und. Co Linwood & Olive

15. FILED 12/19, 1927 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-18 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1927, to Dec. 18, 1927 that I last saw him alive on Dec. 18, 1927, and that death occurred, on the date stated above, at 4:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis, Chronic
Cardiac Decompensation
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Bronchial Asthma
(duration) 7 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam.
12/18, 1927 (Signed) Harold M Roberts, M. D (Address) 910 Argyle Bldg, R.C., 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: Weir Kas — DATE OF BURIAL: 12/19/27 19

20. UNDERTAKER: W. F. Mayberry NC — ADDRESS: City