

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

Do not use this space.
37042
4867

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Jan Primary Registration District No. _____
City Kansas City (No. K.C. General Hospital St. _____ Ward _____)

File No. _____
Registered No. _____

2. FULL NAME

(a) Residence. No. 3218 Waverick St., _____ Ward 5.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 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 DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 27 - 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 10 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Furnace repairer
(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) Illinois

10. NAME OF FATHER Geo. McPherson

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

12. MAIDEN NAME OF MOTHER Helen Hoppe

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

14. INFORMANT Reverend Clerk
(Address) K.C. General Hosp.

15. FILED 1/24 1927 M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-21 1927

17. I HEREBY CERTIFY That I attended deceased from 12-20 1927 to 12-21 1927
that I last saw him alive on 12-21 1927 and that death occurred, on the date stated above, at 1:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial insufficiency

CONTRIBUTORY (SECONDARY) 90 (duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chem. Findings
(Signed) George O. Jac M. D.
12-21 1927 (Address) General Hosp. K.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 Greenwood DATE OF BURIAL 1/24 1927

20. UNDERTAKER O. Mast ADDRESS 1915 East 4

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.

