

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

Do not use this space.

1147

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township St. John Primary Registration District No. 100
 City K.C. Mo. No. 3528 St. John Av. St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

(a) Residence. No. 3528 - St. John 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. _____ 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 Alice A.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 | 1 | 1

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

10. NAME OF FATHER

Wm. H. Hynne

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) No Record

12. MAIDEN NAME OF MOTHER

No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) No Record

14.

INFORMANT Alice A. Hynne
 (Address) 3528 St. John

15.

FILED Jan 13, 28 M. H. Crowe
 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 - 1928

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____ that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at 12:35 AM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

110 Acute Myocarditis
11B
 (duration) yrs. mos. da. 7
 CONTRIBUTORY (SECONDARY) Cold (La Grip)
 (duration) yrs. mos. da. 15

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) Dean J. Pising, M.D.
1/13/28 (Address) 802 ARGYLE BLDG. Kansas City, 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

DATE OF BURIAL

Elmwood Jan 14, 1928

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster K.C. Mo.

K. R. 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.

THIS IS A PERMANENT RECORD

620
2000
3pm