

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Haw
City Hannover

Registration District No. 385

Primary Registration District No. 1027
(No. Old City Hospital)

File No. 4978
Registered No. 638
St. _____ Ward _____

2. FULL NAME

Wm Mochler

(a) Residence. No. 111 E 6th 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 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) Feb 26, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 11 10

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Sum
(STATE OR COUNTRY) _____

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Old City Hospital
(Address) Kansas City Mo

15. FILED 2/13 1928 M M Registrar
Ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 6th 1928

17. I HEREBY CERTIFY That I attended deceased from 12 to 7 1928
that I last saw h. alive on 2-5 1928 and that death occurred, on the date stated above, at 7:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Cancer of Stomach
4603

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Chem & Lab
(Signed) H M Smith, M. D.
77, 1928 (Address) Old City Hospital

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

19. PLACE OF BURIAL, CREMATION OR REMOVAL Woods Cemetery DATE OF BURIAL 2/15 1928

20. UNDERTAKER Wm Waples ADDRESS 600 E. 19th

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.

