

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

Do not use this space.

5050

1. PLACE OF DEATH

County Jackson

Registration District No. 399

File No. _____

Township Law

Primary Registration District No. 1002

Registered No. _____

City Kansas City (No. 2107)

Campbell

St. _____ (Ward) _____

2. FULL NAME

Isaac Felton

(a) Residence. No. 2107 Campbells 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. ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

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

Aug 10 1886

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>41</u>	<u>6</u>	<u>4</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Porter

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Jonestown Ark.

(STATE OR COUNTRY)

10. NAME OF FATHER

Dr M Felton

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Ark

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ark.

(STATE OR COUNTRY)

14.

INFORMANT Rose Felton
(Address) 2107 Campbell

15.

FILED 9/17 1928
REGISTRAR Wm Brown
Cash

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

7-14-19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
239 (duration) _____ yrs. _____ mos. _____ 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? ye

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Wm Turner M.D.

19____ (Address) Deputy Coroner

*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

Highland Cem

DATE OF BURIAL

7/17 1928

20. UNDERTAKER

Hatkins Bros 172 9 Lydia

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.

