

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

Do not use this space.

9127

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. General Hospital)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1306
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1227 E. 11th St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 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 W 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) April 5th 1891

7. AGE. YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 11 17

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

10. NAME OF FATHER Jos. Brown

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

12. MAIDEN NAME OF MOTHER Martha Jones

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

PARENTS

14. INFORMANT Record Clerk
(Address) R.C. General Hosp.

15. FILED 3/25 58 1958 M.M. Grobe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-22 1928

17. I HEREBY CERTIFY, That I attended deceased from 3-16, 1928, to 3-22, 1928, that I last saw h. aw alive on 3-22, 1928, and that death occurred, on the date stated above, at 9:30 P. m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralytic Ileus
Post-operative
myocardial insufficiency
(duration) _____ yrs. mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? yes DATE 3-20-28

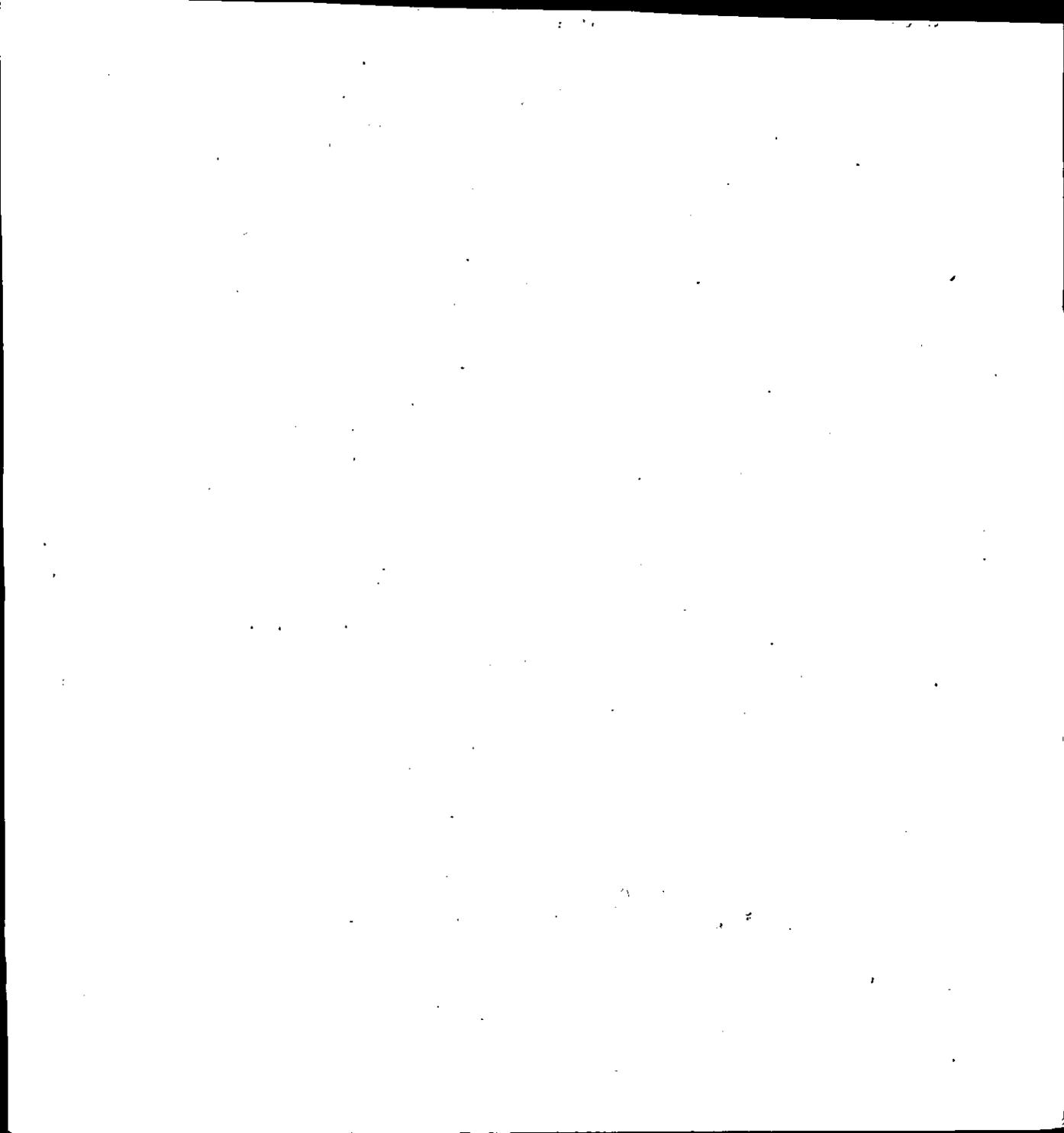
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) P.E. Williams, M.D.
3/23, 1928 (Address) R.C. General Hospital

*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 Elmwood DATE OF BURIAL 3/24 1928

20. UNDERTAKER O.V. Mash ADDRESS City



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1007 Registered No. 1306
 City Wemo (No. 10, General Troops) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1227 6 11 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 F 4. COLOR OR RACE W 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) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

PARENTS

14. INFORMANT (Address) _____

15. FILED 3/23 28 M. J. Crowe REGISTRAR
Asor

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-22-1928

17. I HEREBY CERTIFY That I attended deceased from 3-16-1928 to 3-22-1928 that I last saw him alive on 3-22-1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septicemia
Post-operative
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY Left Granular Eyes
 (SECONDARY) the result of Post-operative
service
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address)

*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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-9127