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

Do not use this space.

9298

File No. b 1482

Registered No. .....

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399

Township: Kaw — Primary Registration District No.: 1002

City: Kansas City (No. St. Lukes Hospital St. ..... Ward)

2. FULL NAME Joseph Keclik

(a) Residence. No. 13 S. Shawnee K.C.K. St., ... Ward. .....
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 10 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57		19	

8. OCCUPATION OF DEESCED
(a) Trade, profession, or particular kind of work: Laborer
(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) Austria-Hungary

PARENTS

10. NAME OF FATHER: James Keclik

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Austria-Hungary

12. MAIDEN NAME OF MOTHER: Agnes---Krach

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Austria-Hungary

14. INFORMANT: Mrs. Frances Keclik
(Address) 13 S. Shawnee Kc 16

15. FILED 4/1, 19 28 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 29 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Accidental fracture of 3-4-5-6 ribs left side
Punctured lung
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Crushed in elevator
..... (duration) ..... yrs. ..... mos. ..... ds.

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

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

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Henry Gorbray, M. D.

3/31, 19 28 (Address) Liberty Tenner

*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: Shawnee — DATE OF BURIAL: Apr. 2 19 28

20. UNDERTAKER: H.W. Gates — ADDRESS: K.C.K.

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.

K. . . . .

Dr.

Lt. Colonel

Commdg.