

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

Do not use this space.

13517

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Spain Primary Registration District No. 1002
 City K.C. Mo. (No. 4415 Park Av.) St. _____ Ward _____

File No. _____
 Registered No. 18701
 St. _____ Ward _____

2. FULL NAME

Richard Everett Messel
 (a) Residence. No. 4415 Park Av. 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. 15 How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug-20-1924</u>		
7. AGE:	YEARS	MONTHS
	<u>3</u>	<u>8</u>
		Days <u>13</u>
		If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Chief</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April, 23-1928

17. I HEREBY CERTIFY, That I attended deceased from April 13, 1928, to April 23, 1928 that I last saw him alive on 4-23-28 at 2:30 PM, and that death occurred, on the date stated above, at 6:55 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
acute (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY acute (SECONDARY) Septicemia
 (duration) _____ yrs. _____ mos. _____ da.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) K.C. Mo.

10. NAME OF FATHER Robert Messel

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

12. MAIDEN NAME OF MOTHER Ruth Folk

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Cultures Ex.
 (Signed) W.D. Leonard, M.D.
4/24, 1928 (Address) 4500 E. 74 St.

*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.

14. INFORMANT Robt. Messel
 (Address) 4415 Park Avenue

15. FILED 4/24, 28 M. M. Conroy REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL Apr 25 1928

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

18. 9029-

4800-12.4

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