

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

Do not use this space.

17014 15131

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1978
 Township Kear Primary Registration District No. 1002 Registered No. 1978
 City Kansas City (No. Kansas City Genl Hosp) St. Mo. (Ward)

2. FULL NAME

Doris William F.
 (a) Residence. No. Heeping Island Ward. 1
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 21 da. 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>widower</u>
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5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 13 1868

7. AGE:	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>2</u>	<u>20</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter
 (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) Texas

10. NAME OF FATHER Don't know

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT Neura Clerk
 (Address) 72. C. Genl Hosp.

15. FILED 5/3 19 28 M. M. Crowe REGISTRAR
acc

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-3 19 28

17. I HEREBY CERTIFY That I attended deceased from 5-2 1928 to 5-3 1928 that I last saw him alive on 5-2 1928, and that death occurred, on the date stated above, at 4:00 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
1000 (duration) yrs. mos. da.
1097A
0311

CONTRIBUTORY (SECONDARY) Myocardial Failure (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: no

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Findings
P. E. Williams, M. D.
 (Signed) 5-3 1928 (Address) Subst. 72. C. Genl Hosp.

*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 Corsicana Tex DATE OF BURIAL 5/3 19 28

20. UNDERTAKER O. V. Mast ADDRESS 1916 East 10

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.

