

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

Do not use this space.

17199

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kanaw Primary Registration District No. 1002
 City Kansas City (No. Kansas City Genl Hosp) St. _____ (Ward)

File No. _____
 Registered No. _____

2. FULL NAME

Eckels, J. F.
 (a) Residence No. 417 E 12th St. 12 Ward _____
 (Usual place of abode)

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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-15 1928

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

17. I HEREBY CERTIFY That I attended deceased from 5-10, 1928, to 5-15, 1928 that I last saw him alive on 5-15, 1928, and that death occurred, on the date stated above, at 5:45 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31 - 1899

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
48 | 11 | 16

Cellulitis of penis
34
136B
129 (duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION OF DECEASED

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

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Nebraska

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

10. NAME OF FATHER H. P. Eckels

5 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Els. Worley

WHAT TEST CONFIRMED DIAGNOSIS? PEWissness

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

(Signed) _____, M. D.
 5 -15, 1928 (Address) Subst K. C. Genl Hosp

14. INFORMANT Reverend Clerk (Address) K. C. General Hosp

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
W. C. Eckels 5/19 1928

15. FILED 5/17 28 1928 M. M. Crowe REGISTRAR
ason

20. UNDERTAKER W. C. Eckels ADDRESS 145 East 16

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Towashp.....
City *N. City* (No.....)

Registration District No. *399*
Primary Registration District No. *1002*

File No.....
Registered No. *2191*
St..... Ward.....

2. FULL NAME

(a) Residence. No..... 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 *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *m* (*write the word*)

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)

14. INFORMANT (Address)

15. FILED *5/17, 1928* *Mrs. M. Brown* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-15* 19 *28*

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..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Celestis of Penis with Peritonitis

CONTRIBUTORY (SECONDARY) *Peritonitis Recto-urethral fistula probably syphilitic origin*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)..... M. D.

*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

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

SUPPLEMENTARY

N. B.—Every statement 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.

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