

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

Do not use this space.

20516

1. PLACE OF DEATH

County Jackson
Township Independence
City Independence (No. _____)

Registration District No. 398
Primary Registration District No. 3019

File No. _____
Registered No. 233
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1427 West Walnut 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 21, 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
0 0 0 0 18 hrs. or 30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Independence
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Everett Kagee

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Dorothy Spear

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

14. INFORMANT Everett Kagee
(Address) 1427 W. Walnut

15. FILED 6/25 1928 F. L. COOK
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-21-1928

17. I HEREBY CERTIFY That I attended deceased from 6/21, 1928, to 6/21, 1928, and that I last saw him alive on 6/21, 1928, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

159
Stomach Borne (Gastric)
H&A
(duration) yrs. mos. da.

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) [Signature], 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 Mound Grove DATE OF BURIAL 6-23 1928

20. UNDERTAKER H. A. Lawson & Son ADDRESS Independence

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 OUTLINES

