

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 27509
 Township Kaw Primary Registration District No. 1007 Registered No. 3585
 City Kansas City (in Kansas City General Hosp) St. _____ Ward _____

2. FULL NAME

Ince, John G
 (a) Residence No. 1210 Tracy St. 2 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 19 / 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 | 9 | 7

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Salesman
 (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) Iowa

10. NAME OF FATHER Thomas Ince

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

12. MAIDEN NAME OF MOTHER Amanda Cole

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

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

15. FILED 8/29 28 M. M. Brewer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-26 1928

17. I HEREBY CERTIFY, That I attended deceased from 8-24, 1928, to 8-26, 1928, that I last saw him alive on 8-24, 1928, and that death occurred, on the date stated above, at 8-24, 1928.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108

CONTRIBUTORY (SECONDARY) Old (duration) yrs. mos. ds.

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) P. E. Williams, M. D.
8-27, 1928 (Address) Supt K. C. General 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 Union Park DATE OF BURIAL 8/29 1928

20. UNDERTAKER O. Mast ADDRESS 1915 East 15

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.

