

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

Do not use this space.

~~27568-11~~  
30583

**1. PLACE OF DEATH**

County Jackson Registration District No.         
 Township Jaw Primary Registration District No.         
 City Kansas City (No. Kansas City General Hosp.) Registered No. 1024  
 (Ward)       

**2. FULL NAME** Laval Louis

(a) Residence. No. 4032 Park St., 15 Ward.  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 11 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 28-1888

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
48 | 0 | 3 |       

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

10. NAME OF FATHER No record

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

12. MAIDEN NAME OF MOTHER No record

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

14. INFORMANT Re. and Clerk  
 (Address) K. C. General Hosp.

15. FILED 9/17 28 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-31 1928

17. I HEREBY CERTIFY That I attended deceased from 8-8, 1928 to 8-31, 1928 that I last saw him alive on 8-31, 1928, and that death occurred, on the date stated above, at 12:30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Generalized lympho sarcoma

(duration) yrs. mos. ds.       

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

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

DID AN OPERATION PRECEDE DEATH? No DATE OF       

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Phys. + Lab. Find + Autopsy  
 (Signed) O. B. Williams, M. D.  
9-1, 1928 (Address) Supd K.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 Memorial pk DATE OF BURIAL 9-18 1928

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

THIS IS A PERMANENT RECORD

All entries should be fully 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.

OCT 4 1954

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

ALL INFORMATION CONTAINED  
HEREIN MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 399 File No. ....  
 Township 7. City Primary Registration District No. 102 Registered No. 3834  
 City No. .... 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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 ..... (duration) yrs. mos. da.  
 (b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) yrs. mos. da.  
 (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 9/17 28 M. M. Grove REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-31-28

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, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Generalized lympho sarcoma, primary form, nodular and cerebral lymph nodes

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

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

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

, 19 (Address)

\*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

19

20. UNDERTAKER

ADDRESS

Every item of information should be stated EXACTLY. PHYSICIANS should file a copy of this DEATH certificate with the health officer, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

**SUPPLEMENTARY**

S-27565-9