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

Do not use this space.
30672

1. PLACE OF DEATH U.S.V.Hosp #67
County Jackson Registration District No. 399 File No.
Township Kaw Primary Registration District No. 100 Registered No.
City Kansas City, Mo. (No. U. S. Veterans Hospital St. Ward)

2. FULL NAME STUBBS, Gail William C-340 606 WOE
(a) Residence. No. 2320 Scott Ave. St. Ward Pvt Co A 137th Inf.
(Usual place of abode) Englewood, Missouri. (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18, 1899

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	6	

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)
(c) Name of employer

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25
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9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Kansas.

PARENTS
10. NAME OF FATHER James W Stubbs
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Chillocothe
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Eva May Southly
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Minnesota.

14. INFORMANT Earl Stubbs (brother)
(Address) Cassville, Mo. Rt 2

15. FILED 9/25 1928 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 24 1928

17.
I HEREBY CERTIFY, That I attended deceased from August 9, 1928, to September 24, 1928 that I last saw him alive on September 24, 1928 and that death occurred, on the date stated above, at 12 Noon.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis, lumbar spine.
About 9 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Tuberculosis of peritoneum; Nephritis parenchymatous, chronic
(duration) yrs. mos. ds.

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Unknown
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X-ray & Laboratory
(Signed) W.E.CHAMBERS, M.D. Medical Officer in Charge
(Address) U.S.V.Hosp. #67 Kansas City, Mo.

7.5
9/25

*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 Mt Hope — DATE OF BURIAL 9/26 1928
20. UNDERTAKER The Taylor Funeral Home Inc — ADDRESS

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 UNFADING INK—THIS IS A PERMANENT RECORD