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

Do not use this space.

33821

1. PLACE OF DEATH

County Jackson — Registration District No. ..... — File No. 4[illegible]3

Township Kaw — Primary Registration District No. ..... — Registered No. .....

City Kansas City (No. Kansas City Genl Hosp St. ..... Ward)

2. FULL NAME George Eleiphet Pace

(a) Residence. No. 1916 Troost St., 4 Ward. (Usual place of abode) ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25, 1924

7. AGE: Years 3 | Months 10 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Carl Pace
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Willa Newman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT Record Clerk (Address) Kansas City Gen. Hosp

15. FILED 10/21, 1928 M M Crowl Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-27 1928

17. I HEREBY CERTIFY, That I attended deceased from 10-26, 1928, to 10-27, 1928 that I last saw him alive on 10-27, 1928, and that death occurred, on the date stated above, at 2:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diphtheria

10 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTOR (SECONDARY) 10 (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

10-27, 1928 (Address) ~~Asst~~ Supt 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: Forest Hill Cemetery — DATE OF BURIAL: Oct 29 1928

20. UNDERTAKER: Eylar Funeral Home — ADDRESS: 1800 Linwood

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD