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.

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

Do not use this space.

35868

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. 4441
City Kansas, Mo (No. Ohio City Hospital St. Ward)

2. FULL NAME Poer Wm
(a) Residence. No. 1726 Michigan 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 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: A-A
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 26, 1880

7. AGE: 48 YEARS: 1 MONTHS: 10 DAYS: 4 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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): Texas

PARENTS
10. NAME OF FATHER: Poer, Andy
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Texas
12. MAIDEN NAME OF MOTHER: Stevenson Eva
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Georgia

14. INFORMANT: Patient himself
(Address) 1726 Michigan

15. FILED 10/31, 1928 M. M. Crowe Assn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

5

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 30 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
92 H Aortic Regurgitation
93 C Acute Cardiac failure
110 B Pleurisy (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory
(Signed) Supt. H. M. Smith, M.D.
10/31, 1928 (Address) General Hospital #2

*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: West Lawn Cemetery — DATE OF BURIAL: 11-1- 1928

20. UNDERTAKER: West Appleton & Jones — ADDRESS: 1600 E. 19 St.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—E... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE C... DEATH in plain terms, 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

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 4411

City K. City (No..... ..... St. ..... Ward)

2. FULL NAME Wm Poer

(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. 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)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26-1879

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
48	10	4	

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY)

14.
INFORMANT .....
(Address)

15. FILED 10/31, 1928 M. M. Browne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 30 1928

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:

.....
.....
.....
..... (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? ..... 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

SUPPLEMENTARY

S. 33828