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.

40516

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 4887
Township Kaw — Primary Registration District No. 1002 — Registered No. 4887
City Kansas City (No. Kansas City Genl Hosp. St. ..... Ward)

2. FULL NAME Gamm John C.
(a) Residence. No. 1504 Walnut St., 1 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 27 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): Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 8 1862

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
66	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Watchman 23A 92D
(b) General nature of industry, business, or establishment in which employed (or employer): 75A
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

PARENTS
10. NAME OF FATHER No record
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER No record
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Record Clerk
(Address) General Hospital

15. FILED 1/4, 1928 M. M. Crowe
REGISTRAR
Assn

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-3 1928

17. I HEREBY CERTIFY, That I attended deceased from 11-17, 1928, to 12-3, 1928, that I last saw him alive on 12-3, 1928, and that death occurred, on the date stated above, at 11:03 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial insufficiency (congestive)
Auricular Fibrillation
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Tuberculosis of lungs, Chronic ..... (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? No
WHAT TEST CONFIRMED DIAGNOSIS? Clin. Findings
(Signed) P. E. Williams, M. D
12-3, 1928 (Address) 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 — DATE OF BURIAL: Dec 6 1928

20. UNDERTAKER: Mrs. C. L. Forster — ADDRESS: K.C. Mo.