

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

Do not use this space.

40932

3312

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. 2402 Harrison)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Geo. White
(a) Residence. No. 2402 Harrison St., _____ Ward.

(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

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Divorced

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

Unknown

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

Jan 1881

7. AGE

47

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Janitor

(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)

MO

10. NAME OF FATHER

Green White

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky.

12. MAIDEN NAME OF MOTHER

Fannie Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky.

14.

INFORMANT (Address)

Green White
2402 Harrison

15.

FILED

12/20/28 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

12-18-1928

17.

I HEREBY CERTIFY, That I attended deceased from 12/16/28 19____, to 12/18/28 19____, that I last saw him alive on 12/18/28, 19____, and that death occurred, on the date stated above, at 11:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency

9217

1113

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Acute Pulmonary Edema
(duration) _____ yrs. _____ mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

Not known

19. DID AN OPERATION PRECEDE DEATH? DATE OF

No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

Examination & Physical Study
(Signed) R. H. Norwood M. D.
17/19, 1928 (Address) 2348 Bellevue, K.C. Mo

*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

West Lawn Cemetery 12/21 19 28

20. UNDERTAKER

ADDRESS

West Lawn Cemetery & Jones 1600 E. 19th

WRITE FULLY, 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.

Wanted to |

Went, affixing + Jones