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

Do not use this space.

1444

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1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City
Registration District No. 1002
Primary Registration District No.
(No. Old City Hospital St. Ward)
File No. 31
Registered No. 31

2. FULL NAME Benjamin A. Clegg

(a) Residence. No. 1525 Virginia St., 2 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 M.
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1870.
7. AGE 58 YEARS MONTHS DAYS 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) Ark.

PARENTS

10. NAME OF FATHER Abram Clegg
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unk
12. MAIDEN NAME OF MOTHER Fannie Hoch
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unk.
14. INFORMANT Amanda Powell
(Address) 1612 Lydia
15. Filed Jan 4, 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-2-29
17. Deputy Coroner
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:
Accidental — automobile
~~Traumatism~~
Fracture of Skull
2.10 M (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) In K.C. Mo (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? ...... DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) [illegible], M. D
1/2/29, 19 (Address) Deputy Coroner

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*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 Highland
DATE OF BURIAL 1/5 1929
20. UNDERTAKER Watkins Bros
ADDRESS 1729 Lydia

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.

UNFADING INK—THIS IS A PERMANENT RECORD

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