

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.

1509

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 98
Registered No. 7 St. Ward

2. FULL NAME

(a) Residence. No. 5-47 Leamont St. 9 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Sarah Johnson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 13 1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 9 21

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) Kentucky
(STATE OR COUNTRY)

10. NAME OF FATHER Fisher Herndon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER A. Thrall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

14. INFORMANT Wife, Sarah Johnson
(Address) 547 Leamont

15. FILED 1/4 29 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1929

17. HEREBY CERTIFY That I attended deceased from Dec 21, 1928, to Jan 4, 1929
that I last saw him alive on Jan 4, 1929, and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocardial Failure
Passive Pulmonary Congestion
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Myocarditis, Endocarditis
Transverse Myelitis (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) St. M. Smith, M. D.

1/4, 1929 (Address) Cent. Hosp. #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 DATE OF BURIAL

Westtown Cemetery 1/10 1928

20. UNDERTAKER ADDRESS

A B Moore 1820 E 18

12500711