

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

Do not use this space.

1585

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. 1002)

Registration District No. 399

File No. _____
Registered No. 1002 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2400 Campbell St. Ward 4
(Usual place of abode)

Length of residence in city or town where death occurred 31 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)

Widowed

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

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

12/1/56

7. AGE

YEARS

MONTHS

DAYS

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

60

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

Janitor
Bakery

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Alabama

10. NAME OF FATHER

Prince Bellamy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

N.C.

12. MAIDEN NAME OF MOTHER

Mary Link

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

N.C.

14.

INFORMANT

(Address)

Hospital Record
Old City Hosp. St.

15.

FILED

1-13-29

2020

2020

2020

2020

2020

2020

2020

2020

MEDICAL CERTIFICATE OF DEATH

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

Jan 9 1929

17.

I HEREBY CERTIFY, That I attended deceased from December 6 1929 to January 9 1929, that I last saw him alive on January 9 1929, and that death occurred, on the date stated above, at 8:35-11 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Failure
129. A
9:10 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Chronic Myocarditis + Nephritis
Semile dementia (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? Physiologist

(Signed) Dr. W. Smith, M. D.

1/10, 1929 (Address) K 6 700

*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

Highland Cemetery Jan 14 1929
Undertaker West Apptment 1000 E. 19th

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, WITH UNFADING INK—THIS IS A PERMANENT RECORD

48
10
9

236
2
2
2

