

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.

1644

1. PLACE OF DEATH

County JacksonRegistration District No. 229Township 2ndPrimary Registration District No. 2002City Kansas CityNo. Kansas City Genl Hosp St. 12 Ward 12File No. 235

Registered No.

2. FULL NAME

(a) Residence. No. 5012 E. 22nd St. 12 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

male

4. COLOR OR RACE

white

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

married

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

Maggie Andrews

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

Dec-18-1855

7. AGE

YEARS

MONTHS

DAYS

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

771028

8. OCCUPATION OF DECEASED

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

Special Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

K.C. Terminal

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Arkansas

10. NAME OF FATHER

Elijah Andrews

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Sarah Hudson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT

(Address)

Reuben Clark
Kansas City Genl Hosp

15.

FILED

1-17, 1929M. M. Cone
asst REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

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

1-161929

17.

I HEREBY CERTIFY, That I attended deceased from

1-16, 1929, to1-16, 1929that I last saw him alive on 1-16, 1929 and that death occurred, on the date stated above, at 8:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hypostatic Bronchopneumonia

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

CONTRIBUTORY (SECONDARY)

Carcinoma of Prostate?

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH?

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

P. W. Williams, M. D.1-17, 1929 (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

DATE OF BURIAL

Mr. MariahJan 18 1929

20. UNDERTAKER

ADDRESS

Mrs. C. L. Forster K.C. Mo.

