

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

Do not use this space.

1746

1. PLACE OF DEATH

County Jackson
Township Howe
City Kansas City (No. Old City Hospital)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 338
St. _____ Ward _____

2. FULL NAME

Edward Prevard
(a) Residence. No. 1401 Virginia St., 2 Ward.

(Usual place of abode)
Length of residence in city or town where death occurred 17 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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-28-1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 6 228

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) Iowa

10. NAME OF FATHER

Louis Prevard

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Mary Davis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Miss

14.

INFORMANT Stephennine Prevard
(Address) 1401 Virginia

15.

FILED 1-23-29 M. M. Crowe
Asst REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-20 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 18, 1927, to Jan 20, 1927, that I last saw him alive on Jan 20, 1927, and that death occurred, on the date stated above, at 1239 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute myocarditis
34
120
200A (duration) yrs. 2 mos. ds.
CONTRIBUTORY, Acute Nephritis
(SECONDARY)
Following infection of (duration) yrs. 12 mos. 12 ds.
Salverson for syphilis

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

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

123, 1929 (Address) Gen. Hosp. No. 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

Topeka Ks

DATE OF BURIAL

Jan 24 1927

20. UNDERTAKER

Nathan Whatchu

ADDRESS

1520 No.

PERMANENT RECORD

Each item of information should be carefully checked. The cause of death 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.

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY FOR
FOREIGN AFFAIRS
MAIL ROOM
MAIL STOP 100
WASHINGTON, D.C. 20250

Every item of information should be as fully supplied. AGD 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County
 Township R. City
 City R. City (No.)

Registration District No. 399
 Primary Registration District No. 1802

File No.
 Registered No. 338
 St. Ward)

2. FULL NAME

(a) Residence. No. St. 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 Cal 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28-1897

7. AGE YEARS MONTHS DAYS
57 5 22
 If LESS than 1 day, hrs. min.

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT
 (Address)

15.

FILED 1/23 19 29 M. M. Brown
Ass REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 20 1929

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (duration) yrs. mos. ds.
 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:

CONTRIBUTORY
 (SECONDARY)

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)....., M. D.
 , 19 (Address)

*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

20. UNDERTAKER

ADDRESS

19

S-1746