

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.

1. PLACE OF DEATH

County Jackson
 Township Law
 City K.C. MO.

Registration District No. 399
 Primary Registration District No. 1002

File No. 1751
 Registered No. 343
 St. _____ Ward _____

2. FULL NAME

Shepherd Willie
 (a) Residence. No. 620 1/2 Charlotte St., 1 Ward.

(Usual place of abode)
 Length of residence in city or town where death occurred 10 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) boy

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23 1920

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
8 0 26 10 09

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work school boy 18
 (b) General nature of industry, business, or establishment in which employed (or employer) 10
 (c) Name of employer 109

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Kansas**10. NAME OF FATHER**Shepherd Willie**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Kansas**12. MAIDEN NAME OF MOTHER**King H.**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Kansas**14.**

Informant Shepherd Willie
 (Address) 620 1/2 Charlotte

15.

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-19 1929

17. I HEREBY CERTIFY That I attended deceased from 12-23-1929 to 1-19-1929
 that I last saw h. live on 1-19-1929, and that death occurred, on the date stated above, at 2:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic Meningitis
Acute Nephritis
Beginning Lobar Pneumonia
 (duration) yrs. mos. 28 ds.

CONTRIBUTORY (SECONDARY) Acute nephritis
Pneumonia
 (duration) yrs. mos. ? ds.

18. WHERE DISEASE CONTRACTED

AT WHAT PLACE OF DEATH? Home

DID PREDECESSOR PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) Howard M. Smith, M. D.
1/20, 1929 (Address) Old City 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**

West Lawn Cemetery 1-23 1929

20. UNDERTAKER**ADDRESS**

West. Appleson & Jones 1600 E. 19th St.

