

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

Do not use this space.

1833

1. PLACE OF DEATH

County Salmon
Township Gen
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 420
Registered No. 420 Ward)

2. FULL NAME

(a) Residence. No. Dodge City Kansas Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

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

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

9-23-18

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ____ hrs. or ____ min.

56

4

2

8. OCCUPATION OF DECEASED

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

Salesman

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

New London

10. NAME OF FATHER

Newton C. Everett

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Dodge City

12. MAIDEN NAME OF MOTHER

Mary Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Dodge City

14. INFORMANT

(Address)

Reina Clerk
Kan. City Gen. Hosp.

15. FILED

1-28-29 M. M. Carr
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan. 25 1929

17.

I HEREBY CERTIFY That I attended deceased from Jan 25 1929 to Jan 25 1929 that I last saw him alive on Jan 25 1929, and that death occurred, on the date stated above, at 6:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A

CONTRIBUTOR (SECONDARY)

(duration) ____ yrs. ____ mos. ____ ds.

(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. E. Williams, M. D.

1-26 1929 (Address) Subt K. C. Gen. 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

Chenwood

1-28 1929

20. UNDERTAKER

ADDRESS

O V Mart Kan. City

W. 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.

1000

10

10

(Faint handwritten notes)

**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.....
City St. City (No.....)

Registration District No. 399
Primary Registration District No. 1002

File No.....
Registered No. 426
St..... Ward.....

2. FULL NAME

Everett, F. J.

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

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 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) 9-23-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 4 2

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

1/28-29 M. M. Browne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25-1929

17.

I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

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

16. 17. — Every item of information should be carefully applied. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-1833