

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

Do not use this space.

1915

1. PLACE OF DEATH

County Gackson
Township Law
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 509
St. _____ Ward _____

2. FULL NAME

Harbour Wilson
(a) Residence No. 304 Main St. 1 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 30 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)

Single

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

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

Jan 11 - 1873

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
56	0	16	

8. OCCUPATION OF DECEASED

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

Harbour Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ienn

12. MAIDEN NAME OF MOTHER

Adeline Blinger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ienn

14.

INFORMANT Rena Clark
(Address) Kansas City Genl Hosp

15.

FILED 2-1-29 J. M. Brown
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

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

Jan 27 1929

17.

I HEREBY CERTIFY, That I attended deceased from Jan 22, 1929, to Jan 27, 1929 that I last saw him alive on Jan 27, 1929, and that death occurred, on the date stated above, at 5:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Trachea

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: no DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED THE DIAGNOSIS? Gen. Find + Cent. Hosp
(Signed) P. C. Williams, M. D.

1-27, 1929 (Address) Supt T.C. Genl Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL / DATE OF BURIAL

At Home 1/28-29

20. UNDERTAKER

[Signature] ADDRESS 1916 East 15

K. 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.

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