

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

Do not use this space.

6414

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township Haw Primary Registration District No. \_\_\_\_\_ Registered No. 573  
 City Kansas City (No. Kansas City, 4th Ward) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Bouldin Mentor

(a) Residence. No. 3220 Campbell St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28, 1875

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
53 | 9 | 7

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work 1. Salesman  
 (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) Mo.

10. NAME OF FATHER J. E. Bouldin

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

12. MAIDEN NAME OF MOTHER Minnie Thompson

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

14. INFORMANT Deirda Clark (Address) R.C. General Hosp.

15. FILED 2/5/29 1929 M. M. Currie REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-27, 1929, to 2-5, 1929, that I last saw him alive on 2-5, 1929, and that death occurred, on the date stated above, at 4:05 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

1. Ascending Pylo. regurgitation  
23  
34  
132A (duration) \_\_\_\_\_ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Tuberc. and early Pylo. (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Mo.

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Che. Exam. and Autopsy

(Signed) P. E. Williams, M. D.

, 1929 (Address) Gen. Hosp. R.C. Mo.

\*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 Sedalia Mo. DATE OF BURIAL 1/8 1929

20. UNDERTAKER B. W. Newcomer and W. O. Gledhill and Co. ADDRESS Sedalia Mo.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. ....  
 Township Kaw Primary Registration District No. 1007 Registered No. 573  
 City Keosauqua (No. R. 6 General Topog) St. .... Ward)

**2. FULL NAME**

Mentor Bouldin

(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 wh 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
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**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 3/5, 1929 M M Crowe REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5-1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... 19.....  
 that I last saw h..... alive ..... 19....., and that death occurred, on the date stated above at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Ascending Pyelonephritis

CONTRIBUTORY (duration) yrs. mos. ds. Tuberc. Early Pyelonephritis  
 SECONDARY Septicemia (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?.....  
1/6  
 (Signed)....., M. D.  
1/5, 1929 (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  
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20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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