

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

Do not use this space.

6478

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City (No. General Hospital)

399

Registration District No. 1992
Primary Registration District No. 2

File No. 658
Registered No. 658 St. _____ Ward _____

2. FULL NAME

Sale, Elwalter
(a) Residence No. 1214 Co. 19th St.
(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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown

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

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

7. AGE - YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. about 4¹ Unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT West Appleton & Jones (Address) St. Co. 770

15. FILED 2-8-29 1929 M. M. Lome Registrar Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-26-29 to 2-4-29, 1929 that I last saw him alive on 2-4-29, and that death occurred, on the date stated above, at 7:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic Cerebro-spinal meningitis

CONTRIBUTORY (SECONDARY) Typhemia (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED St. Co. IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical and laboratory
(Signed) H. M. Smith M. D. 2-7-29 (Address) old City Hospital

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kahoka, Mo. DATE OF BURIAL 2/9 1929

20. UNDERTAKER West Appleton & Jones ADDRESS 600 E. 19th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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