

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

Do not use this space.  
**6532**

**1. PLACE OF DEATH**

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

**399**  
Registration District No.  
Primary Registration District No. **1002**

File No. \_\_\_\_\_  
Registered No. **695**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Harold Williams Peyton  
(a) Residence. No. Wooden Hotel 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** male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb 21 1908

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>20</u>	<u>11</u>	<u>19</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Houseman  
(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)** S Carolina

**10. NAME OF FATHER** William Haver

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** S Carolina

**12. MAIDEN NAME OF MOTHER** Earl Parks

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

**14. INFORMANT** Reed Blank  
(Address) Kansas City Gen Hosp

**15. FILE** 211 29 M M Cm  
REGISTRAR Asst

**MEDICAL CERTIFICATE OF DEATH**

**3**  
**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 2-10-1929

**17. I HEREBY CERTIFY, That I attended deceased from** 2-4-1929, to 2-10-1929, that I last saw him alive on 2-10-1929, and that death occurred, on the date stated above, at 1:25 P.M.

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

General Septicemia  
7:30 (duration) yrs. mos. ds.  
15/10

**CONTRIBUTORY (SECONDARY)** Brain Abscess  
Tuberculosis (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED** Now  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

**19. DID AN OPERATION PRECEDE DEATH? DATE OF** \_\_\_\_\_  
**20. WAS THERE AN AUTOPSY?** \_\_\_\_\_

**WHAT TEST CONFIRMED DIAGNOSIS?** \_\_\_\_\_  
(Signed) P E Williams M. D.  
2-10-1929 (Address) K C General Hospital

\*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** Carson Kansas **DATE OF BURIAL** 2/11-1929  
**20. UNDERTAKER** O'Neil ADDRESS 1915 East 15

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

M. 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.

