

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

Do not use this space.

6549

1. PLACE OF DEATH

County.....Jackson.....
Towship.....KAW.....
City.....Kansas City.....

Registration District No. 399
Primary Registration District No. 1002
General Hospital

File No. 712
Registered No. 712
St. _____ Ward _____

2. FULL NAME

Swain Giles,

(a) Residence. No. Not known St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (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 Anna Giles

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. Abt 32

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Henry Giles

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

12. MAIDEN NAME OF MOTHER Dora Randall

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

14. INFORMANT Mrs. Rick (Address) 1830 Northern Blvd., Indep. Mo.

15. FILED 2-12-29 M M Connor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Septicemia
Infected Long Fract
of leg, (cause unknown)
(duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____ WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Flavelly M. Hall, M. D.
2-11-1929 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or 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 Maple Hill DATE OF BURIAL 2/12 19 29

20. UNDERTAKER P. V. Lindsey & Sons Inc. ADDRESS City Mo

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.

237
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