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

Do not use this space.

6602

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No. B 767
City Kansas City (No. 1116 E. 45th St. St. Ward)

2. FULL NAME Aloy M. Michael
(a) Residence. No. 1116 E. 45th St. St., 15 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 16 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~~ Winnie J. Michael

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 20, 1867

7. AGE: Years 61 — Months 9 — Days 23 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): K.C. Park Board
(c) Name of employer

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9. BIRTHPLACE (CITY OR TOWN) Dont know
(STATE OR COUNTRY) Indiana

2

PARENTS

10. NAME OF FATHER John Michael
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont know
(STATE OR COUNTRY) Indiana
12. MAIDEN NAME OF MOTHER Catherine Hardman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont know
(STATE OR COUNTRY) Indiana

14. INFORMANT Mrs. Winnie J. Michael
(Address) 1116 E. 45th St.

15. FILED 2-15-29 M M Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 13 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec-8, 1929, to Feb-14, 1929 that I last saw him alive on Feb-13, 1929, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinomer Prostrate

51C

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Same

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) [signature], M.D.
, 19 (Address) 4525 Prospect Ave

*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: Mt Moriah — DATE OF BURIAL: 2/16 1929

20. UNDERTAKER: Freeman Mortuary — ADDRESS: 104 W. 42nd St.

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.

4523 [illegible]
[illegible].0118.

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