

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

Do not use this space.

6758

1. PLACE OF DEATH

County Jackson
Township Kan
City Hanson City

399
Registration District No. 1002
Primary Registration District No.

File No. _____
Registered No. 924 Ward

2. FULL NAME

(a) Residence No. 555 main St., _____ Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 37 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
-----------------------	----------------------------------	--

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-29-1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>5</u>	<u>25</u>	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Carrie Hall

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

12. MAIDEN NAME OF MOTHER Lettie Wymore

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

14. INFORMANT Reed Clark (Address) Hanson City Gen Hosp.

15. FILED 2-25-29 M M Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-24-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-21-1929, to 2-24-1929 that I last saw him alive on 2-24-1929, and that death occurred, on the date stated above, at 2:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
IOB

CONTRIBUTORY (SECONDARY) IOB (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? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical findings
(Signed) P. B. Williams, M. D.

2-24-1929 (Address) Dept. H. B. Gen Hosp

*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 _____

Mt. Washington 2/25/1929

20. UNDERTAKER Mrs. L. L. Foster ADDRESS K.C. 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.

172
1
2
2

