

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

Do not use this space.

6822

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City, Mo.

Registration District No. 399
Primary Registration District No. 1002

File No. 988
Registered No. 988
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1416 Chelmsford Ave. Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

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.

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 married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 1880

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>49</u>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Pittsburg, Penn.
(STATE OR COUNTRY)

10. NAME OF FATHER Rivers, Joseph

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

12. MAIDEN NAME OF MOTHER Jackson, Anna

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

14. INFORMANT Mary Rivers (wife)
(Address) 1416 - Independence

15. FILED 728 19 29 m. m. Levine
REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 2-15-1929 to 2-24-1929 that I last saw him alive on 2-27-1929 and that death occurred, on the date stated above, at 11:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Retro-Cerebral Abscess

1213
1230 (duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY (SECONDARY) Colon fistulae
(duration) 7 yrs. 7 mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID IN OPERATION PRECEDE DEATH? Yes DATE OF 2-19-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) H. M. Smith, M. D.

2/25. 1929 (Address) Old City 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 Blue Ridge Lawn DATE OF BURIAL Mar 1 1929

20. UNDERTAKER AB Moore ADDRESS 1820 E 18

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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2
2
30

