

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

Do not use this space.

10824

**1. PLACE OF DEATH**

County Jackson  
Township Kan  
City Kansas City (No. Kansas City Genl Hosp)

Registration District No. 500  
Primary Registration District No. 1000

File No. 1033  
Registered No. 1033  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James M. E.

(a) Residence. No. 1215 Park av. St. 9 Ward \_\_\_\_\_

(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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-22-1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
88 2 25

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Lidster  
(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) Jackson Co. Missouri

PARENTS

10. NAME OF FATHER Jeremiah James

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

12. MAIDEN NAME OF MOTHER Louisa Turner

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

14. INFORMANT Record clerk  
(Address) Kansas City Genl Hosp

15. FILED 3/17, 19 29 M. M. Kosman REGISTRAR  
assr

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17-1929

17. I HEREBY CERTIFY, That I attended deceased from 3-5-, 1929, to 3-17-, 1929, that I last saw him alive on 3-17-, 1929, and that death occurred, on the date stated above, at 12:45 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Carcinoma of Penis  
terminus bronchopneumonia

CONTRIBUTORY (SECONDARY) 49 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

1 DID AN OPERATION PRECEDE DEATH? no DATE OF 3-16-29

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS

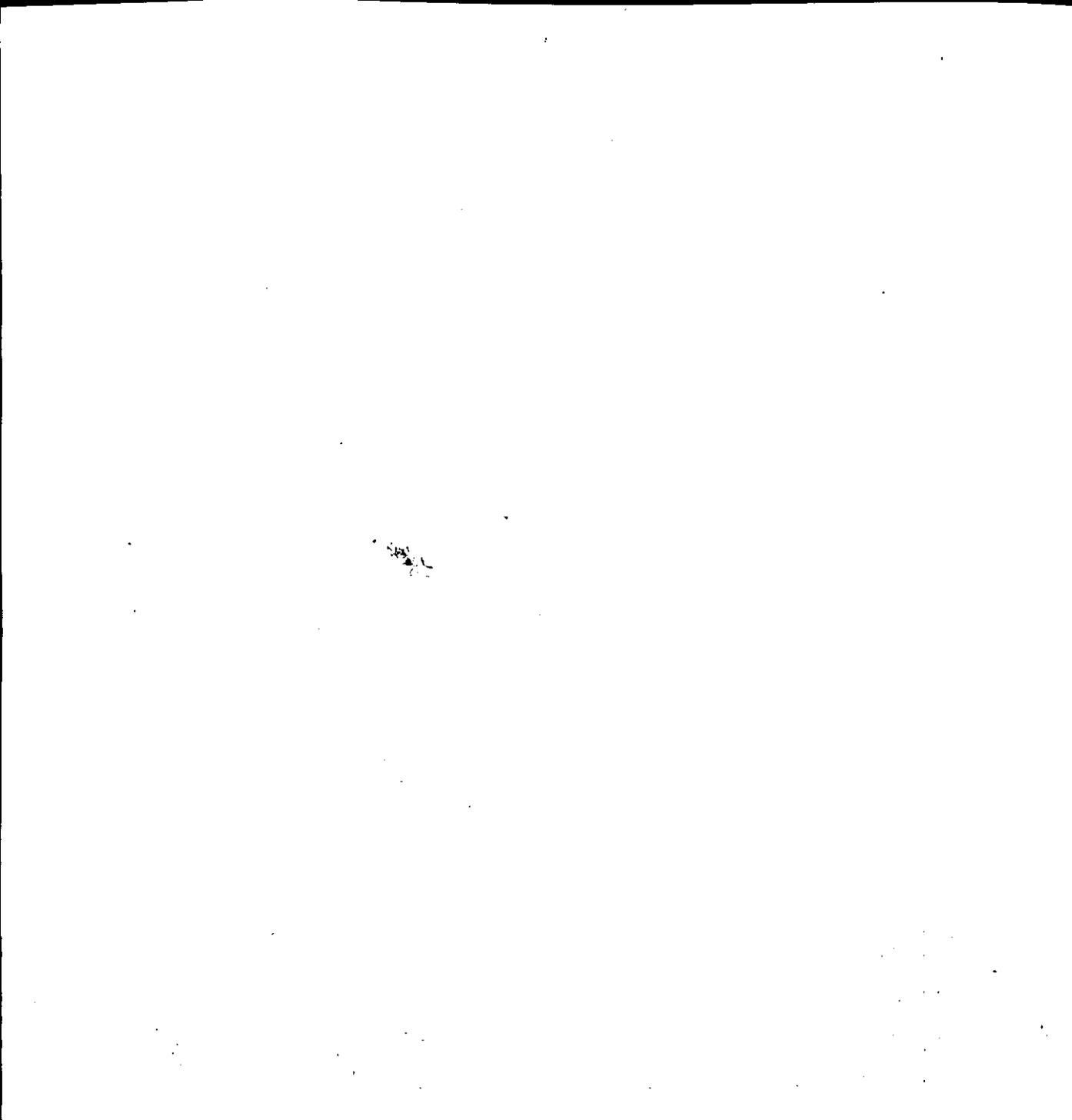
(Signed) P. E. Williams, M. D.

3-17, 19 29 (Address) Sup't. K.C. Genl 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 Elmwood DATE OF BURIAL 1929

20. UNDERTAKER A. P. Doehler ADDRESS 1415 E 15



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399 File No.....  
 Township X. City Primary Registration District No. 1002 Registered No. 1333  
 City X. City (No. ....) St. .... Ward.....

**2. FULL NAME**

(a) Residence. No. .... St. .... 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

*M. E. Jones*

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) ..... yrs. .... mos. .... ds.  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 3/17, 1929 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/17 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, h..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) ..... yrs. .... mos. .... ds.  
 (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?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

3/19 1929

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-16824