

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

Do not use this space. 11086
~~11087~~
1616

1. PLACE OF DEATH

County Jackson
Township Kan
City Kansas City

Registration District No. 1002

Primary Registration District No. _____

File No. _____

Registered No. _____

St. _____ Ward) _____

2. FULL NAME

Bourman Miford
(a) Residence. No. Mason City, Illinois 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. 4 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)

Widower

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

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

June 5, 1878

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

50

9

24

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)

Ill.

10. NAME OF FATHER

Wm. Bourman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Penn.

12. MAIDEN NAME OF MOTHER

Ellen Mink

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

14.

INFORMANT

(Address)

Reverend Clerk
M. C. General Hosp.

15.

FILED

4/3, 1929 M. M. Crowe
asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

3-29 1929

17.

I HEREBY CERTIFY, That I attended deceased from 3-26, 1929 to 3-29, 1929 that I last saw him alive on 3-29, 1929, and that death occurred, on the date stated above, at 6:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Poly cystic Kidney

1331

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

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

3-29, 1929 (Address) Supt. M. C. General 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

Leeds

4/4/ 1929

20. UNDERTAKER

ADDRESS

U. V. Mast

1915 E 15

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.

