

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

Do not use this space.

15004-~~6~~B
2.136

1. PLACE OF DEATH

County Jackson
Township Law
City Kansas City (No. General Hospital #2)

Registration District No. 399
Primary Registration District No. 002

File No. 2.136
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2401 Bellvue 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. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
64 11 13

8. OCCUPATION OF DECEASED

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

Labor

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

10. NAME OF FATHER Quallay Wallace

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

12. MAIDEN NAME OF MOTHER Nellie

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

14. INFORMANT Record Clerk
(Address) Acad City Hospital

15. FILED 5/28/29 M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 20 1929

17. HEREBY CERTIFY, That I attended deceased from March 21, 1929, to April 20, 1929, that I last saw him alive on April 20, 1929, and that death occurred, on the date stated above, at 6:45 A. M.

1929 THE CAUSE OF DEATH WAS AS FOLLOWS:

1948 Surgical Shock

CONTRIBUTORY (SECONDARY) Amputation of femur
right leg fracture (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED injury not obtainable, occurred some time ago
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF April 27, 1929

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam
(Signed) N. M. Smith, M. D.

30, 1929 (Address) Genl Hosp #2

*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 K.P. Western Dental School DATE OF BURIAL 5/23 1929

20. UNDERTAKER Mo state Anatomical Board ADDRESS _____

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.

