

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

Do not use this space.

18281
2326

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Jean Primary Registration District No. 1002

City Kansas City No. Kansas City Gen. Hosp. 1002 Ward

File No. _____

Registered No. _____

2. FULL NAME

August Honles

(a) Residence. No. 45 Edmond St. Joseph mo. 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) Single

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work work
(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) Germany

10. NAME OF FATHER Christopher Honles

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

12. MAIDEN NAME OF MOTHER Vertude Thompson

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

14. INFORMANT Reverend Clerk (Address) K.C. General Hosp.

15. FILED 5/20 1929 M. M. Croire REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-15 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-11 1929 to 5-15 1929 that I last saw him alive on 5-15 1929 and that death occurred, on the date stated above, at 11:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 10/10 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Fluor. Findings of
(Signed) P. Williams M. D.

5-16 1929 (Address) Subt 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 Leido DATE OF BURIAL 5/27 1929

20. UNDERTAKER W. Mast ADDRESS 1915 East 15

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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