

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

File No. **26999**

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 001
 City St Joseph (No. State Hospital for Insane #2 St. _____ Ward)

Registered No. 957

2. FULL NAME

(a) Residence. No. State Hosp #2 St. Harris Ward.

(Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 5 mos. _____ da. 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 Mrs Morton Matton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 4, 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
31 9 8

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Mons Matton

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

12. MAIDEN NAME OF MOTHER Johanna Olson

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

14. INFORMANT State Hosp #2
 (Address) St Joseph

15. FILED 12 1929 John L. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 1929

17. I HEREBY CERTIFY, That I attended deceased from mon 25, 1929, to Aug 12, 1929 that I last saw h. e. alive on Aug 12, 1929, and that death occurred, on the date stated above, at 1:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis of Duodenum
83
38 (duration) yrs. 5 mos. _____ da.

CONTRIBUTORY (SECONDARY) malaria
 (duration) yrs. 1 mos. 6 da.

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? clinical
 (Signed) [Signature], M. D.
8-12, 1929 (Address) State Hosp #2 St Joseph

*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 _____

Kansas City, Mo Aug 14, 1929

20. UNDERTAKER _____ ADDRESS _____

Heaton Bell & Bowmer 319 S. 10th St.
Funeral Home

WRITE PLAINLY, WITH UNFAADING 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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