

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

Do not use this space.

30728

1. PLACE OF DEATH

County Jackson
Township Rau
City Kansas City (No. General Hospital St. Ward)

399

Registration District No.
Primary Registration District No. 1002

File No.
Registered No. 3745

2. FULL NAME

(a) Residence. No. 917 Washington St. 1 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>3</u> (with the word)
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-1-29

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, <u>11</u> hrs. or <u> </u> min.
<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Albert Pearson

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

12. MAIDEN NAME OF MOTHER Mary Stover

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

14. INFORMANT Record Clerk
(Address) K.C. Genl Hosp

15. FILED 9/3, 1929 M. M. Crowell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-3-1929

17. I HEREBY CERTIFY, That I attended deceased from 9-3, 1929, to 9-2, 1929 that I last saw him alive on 9-2, 1929, and that death occurred, on the date stated above, at 7:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity

159 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 161a (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) O. E. Williams, M. D.

9-3, 1929 (Address) 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 Leeds DATE OF BURIAL 9/5/29

20. UNDERTAKER O. M. West ADDRESS 1915 Oak 15

WRITE PAINLY, 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.

Handwritten signature or scribble, possibly containing the characters "何子" (He Zi).