

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

Do not use this space.

33701

1. PLACE OF DEATH

County Jackson
Township New
City Kansas City

Registration District No. 399
Primary Registration District No. 1003
(No. St Joseph Hospital)

File No. _____
Registered No. 4152
St. _____ Ward _____

2. FULL NAME

(a) Residence No. Harold Wm Grant St. _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

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 Lillian B. Grant

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-1-1898

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
30 10 3

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). Sells shoe Co.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Mass.

PARENTS
10. NAME OF FATHER A.D. Grant
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) no record
12. MAIDEN NAME OF MOTHER _____
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) no record

14. INFORMANT Lillian B. Grant
(Address) 4434 Flora

15. FILED 10/6, 19 29 M. D. Erwin
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-4 19 29

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct 4, 1929, that I last saw him alive on Oct 4, 1929, and that death occurred, on the date stated above, at 4:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Streptococci Peritonitis
121A
129 (duration) yrs. mos. 5 ds.
CONTRIBUTORY Gangrenous Appendicitis
(SECONDARY) (duration) yrs. mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept 29-1929
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? operation
(Signed) Henry J. Jones, M. D.
10/5, 1929 (Address) Kansas City Mo

*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 mt moriah DATE OF BURIAL Oct 9 19 29

20. UNDERTAKER Mrs. C L Foster ADDRESS 918 Brooklyn

WRITE MAINLY, 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.

4101 Account

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