

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

Do not use this space.

33746

4198

**1. PLACE OF DEATH**

County Jackson Registration District No. 399

Township Jean Primary Registration District No. 1002

City Kansas City (No. Kansas City Genl Hosp St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

**2. FULL NAME** Edward Harrison

(a) Residence. No. 521 Bennington St. 10 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-6-1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
52 6 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Laborer

(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) Ky.

PARENTS

10. NAME OF FATHER Wm Harrison

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

12. MAIDEN NAME OF MOTHER Ethel Embury

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

**14. INFORMANT**

Reverend Clerk  
(Address) Kansas City Genl Hosp

**15. FILED**

10-10-29 M. M. Crowe  
asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-10-1929

17. I HEREBY CERTIFY, That I attended deceased from 10-7-1929 to 10-10-1929 that I last saw him alive on 10-10-1929 and that death occurred, on the date stated above, at 8:50 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Syphilitic Arteritis and Chronic Myocarditis  
34  
93 C

CONTRIBUTORY (SECONDARY) Syphilis of central nervous system (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

NOT IN PLACE OF DEATH. \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHICH TEST CONFIRMED DIAGNOSIS Autopsy  
(Signed) P. C. Wellens, M. D.

10-10-1929 (Address) Subt 72 C Gen. 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**

Keystoville Mo

**DATE OF BURIAL**

Oct 11 1929

**20. UNDERTAKER**

John A. Muzel

**ADDRESS**

1415 311

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.

MARGIN RESERVED FOR BINDING

V. S. No. 2.

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