

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

Do not use this space.

37409
4879

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Law Primary Registration District No. 1002
City Kansas City (No. Kansas City Genl Hosp) St. _____ (Ward)

File No. _____
Registered No. _____

2. FULL NAME

William White
(a) Residence. No. 547 Walnut 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 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Divorced</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 17, 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>56</u>	<u>10</u>	<u>10</u>	

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER John White

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

12. MAIDEN NAME OF MOTHER Susan Cross

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

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

15. FILED 11/27, 1929 M. M. Cross REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-27 1929

17. I HEREBY CERTIFY, That I attended deceased from 8-10, 1929 to 11-27, 1929 that I last saw him alive on 11-27, 1929 and that death occurred, on the date stated above, at 6:15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
31 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Myelogenous Leukemia (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS Chem. Ind. & Autopsy
(Signed) P. E. Williams, M. D.
11-27, 1929 (Address) Supt K.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 M. M. Marys DATE OF BURIAL Nov-28, 1929

20. UNDERTAKER Mrs. C. L. Forster ADDRESS K.C. Mo.

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.

