

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

Do not use this space.

40962
5370

1. PLACE OF DEATH

County Jackson
Township Blue
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
(No. Seeds Hosp)

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

2. FULL NAME

John Smith

(a) Residence. No. 5-12 E. 5-7 St. 6 Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Dora Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29 - 1910

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>59</u>	<u>6</u>	<u>29</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER Washington Smith

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

12. MAIDEN NAME OF MOTHER Elizabeth Moore

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

14. INFORMANT J.C. Tuberculosis Hosp.
(Address) Rede Station Kansas City Mo

15. FILED 12/28/29 M. M. Crowl
REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-28 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-29, 1928 to 12-28, 1929
that I last saw him alive on 12-27, 1929, and that death occurred, on the date stated above, at 12:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A 51 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 51 (duration) yrs. mos. ds.

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 Microscopical
(Signed) George C. Deh M. D.

1/28, 1929 (Address) 202 Angyle Bldg

*State the DISEASE CAUSING DEATH, or in death from violence CAUSE OF DEATH (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Haldron Mo DATE OF BURIAL 1/29/29

20. UNDERTAKER W. F. Mayberry ADDRESS W. F. Mayberry N. E. City 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.

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