

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

Do not use this space.

40966

1. PLACE OF DEATH

County Jackson Registration District No. 700
Township Kan Primary Registration District No. 700
City Kansas City (No. Kansas City General Hospital) St. 9 Ward

File No. 5375
Registered No. 5375
St. 9 Ward

2. FULL NAME

(a) Residence. No. 3008 1/2 B 15 St. 9 Ward. (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 Mamie Margret Mason

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3-1899

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
30 11 24

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Ed Mason

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

12. MAIDEN NAME OF MOTHER Callie Oinker

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

14. INFORMANT Record Clerk
(Address) Kansas City Genl Hosp.

15. FILED 7 29 29 M. M. Crowder REGISTRAR
user

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-29-1929

17. I HEREBY CERTIFY, That I attended deceased from 12-25-, 1929, to 12-29-, 1929
that I last saw him alive on 12-29-, 1929, and that death occurred, on the date stated above, at 11:03 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ruptured appendix with Peritonitis

12 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1170 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH. DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) P E Wellbaum, M. D.

12-29, 19 29 (Address) Sup. K. B. 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 Springfield Mo DATE OF BURIAL Dec 30 1929

20. UNDERTAKER Mrs C L Foster ADDRESS 918 Broadway

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.

