

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

Do not use this space.

1211

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township New Primary Registration District No. 1002
 City Kansas City (No. 813 E 10th) St. _____ Ward _____

2. FULL NAME Edw. Trower
 (a) Residence. No. 813 E 10th St. 2 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.

File No. _____
 Registered No. 211
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE bal. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27, 1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
48 6 17

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

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

10. NAME OF FATHER George Trower

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

12. MAIDEN NAME OF MOTHER Charlotte

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

14. INFORMANT Rudolf Trower
 (Address) 813 E 10th

15. Jan 15 1930 M. M. Crowe REGISTRAR
ans

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1929 to Jan 9 1930 that I last saw him live on Jan 9 1930 and that death occurred, on the date stated above, at 5:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

B. A. acute dilatation
of the stomach
due to
acute gastritis
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY (SECONDARY) Influenza - 2 wks
Gastritis (duration) yrs. mos. ds. 3

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Jos. J. Jones M. D.
 (Address) 1612 E 12th

*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 Highland Cem. DATE OF BURIAL 1/16 1930

20. UNDERTAKER Watkins Bros ADDRESS 1779 Lydia

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.

J. A. Jones.