

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

Do not use this space.

**5009**

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Wau Primary Registration District No. 1007  
City Kansas City (No. K.C. Genl Hosp) St. \_\_\_\_\_ Ward)

File No. \_\_\_\_\_  
Registered No. 5009  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

Itchig Esperson  
(a) Residence. No. 820 W. 3rd St., 5 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 21 - 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
20 9 21

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Clerk  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Milan Mo  
(STATE OR COUNTRY)

10. NAME OF FATHER Leman E. Esperson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Ruth Peyton

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

14. INFORMANT Dever Clerk  
(Address) K.C. General Hosp

15. FILED 7/13 30 P.M. Cronin REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-12-30

17. I HEREBY CERTIFY, That I attended deceased from 2-9-30 to 2-12-30, 1930  
that I last saw him alive on 2-12-30, 1930, and that death occurred, on the date stated above, at 8:30 P.M.

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

Epidemic cerebral spinal meningitis

18. CONTRIBUTORY (SECONDARY) 24  
(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 Clin + Lab Findings  
(Signed) R.E. Williams M. D.

2-13-30 (Address) Subt K.C. 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 Edina Mo DATE OF BURIAL 2-13-30  
19

20. UNDERTAKER O.H. Mast ADDRESS 1915 E 15

AGE should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important.

