

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

Do not use this space.

8692

1. PLACE OF DEATH

County Jackson
Township 2nd
City Kansas City

Registration District No. 399

Primary Registration District No. 1007

File No. 1059
Registered No. 1059
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Harold Clark
(Usual place of abode) 917 Forest Ave. 7 Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>54</u>	<u>7</u>	<u>16</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Illinois

PARENTS

10. NAME OF FATHER James Clark

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

12. MAIDEN NAME OF MOTHER Mary Harvey

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

14. INFORMANT Reina Clark
(Address) Kansas City Gen. Hosp.

15. FILED 10, 1930 M. M. Casper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-8 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-25 1930 to 3-8 1930 that I last saw him alive on 3-8 1930 and that death occurred, on the date stated above, at 5:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Subar Pneumonia following a strangulated inguinal hernia
122A
10B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1180A (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3-3-30

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) P. E. Williams, M. D.
3-8 1930 (Address) Dept. 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 Maple Hill DATE OF BURIAL 3-10-30

20. UNDERTAKER O. U. Mast ADDRESS 1915 East 15

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.

