

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

Do not use this space.

8788

1. PLACE OF DEATH

County Jackson
Township Kan.
City Kansas City (No. St. Marys' Hospital)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1155
St. _____ Ward _____

2. FULL NAME Henry A. Altman

(a) Residence. No. 3203 Washington St., _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 17 1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	72	--	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Jeweler Retired--15 years
(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

10. NAME OF FATHER Clemens Altman

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

12. MAIDEN NAME OF MOTHER Wilminia Ronling

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

14. INFORMANT Mrs Jas V Straub
(Address) 3283 Washington

15. FILED 5/16 20 M. M. Crowe
REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 14 1930 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 10, 1930, to Mar 14, 1930, that I last saw him alive on Mar 14, 1930, and that death occurred, on the date stated above, at 2:50 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prostatic acute interstitial. Secondary to prostatic hypertrophy resulting in acute retention and acquired bronch pneumonia
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Prostatic hypertrophy - 3 yrs
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 107A
IF NOT AT PLACE OF DEATH 137

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Clarence S. Papall M. D.
3/15 1930 (Address) Kansas City Mo 1135 Kelly Bldg

*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 Emporia, Kansas DATE OF BURIAL Mar 17 1930

20. UNDERTAKER Quirk & Tobin--20 - Linwood
ADDRESS _____

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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