

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

Do not use this space.

8854

**1. PLACE OF DEATH**

County Jackson Registration District No. 399

Township Haw Primary Registration District No. 003

City Kansas City No. 1404 Troost

File No. 1252

Registered No. 1252

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1404 Troost 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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) seperated

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Della Maria Litel

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febr 16 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	63	1	2	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Stock & Bond  
 (b) General nature of industry, business, or establishment in which employed (or employer) Salesman  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) High Eagle Iowa  
 (STATE OR COUNTRY)

10. NAME OF FATHER Lewallen Litel

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Gilbert Hays Litel  
 (Address) 2200 1/2

15. FILED 3/20 1930 M. M. Crowe REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH** Tuesday

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 18 1930

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ noon \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Leukemia myocarditis  
70B 1930  
27  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis  
 (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? yes

WHAT TEST CONFIRMED DIAGNOSIS? Wet test by  
3/18 (Signed) Shanty Thayer, M. D.

3/18 1930 (Address) Highway 1000

\*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 Edinwood Cremation DATE OF BURIAL 3/20 1930

20. UNDERTAKER Erglar Funeral Home 1800 Edinwood 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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