

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

Do not use this space.

012625

File No. **1552**
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Johnson Registration District No. _____
Township Kear Primary Registration District No. _____
City Kansas City (No. Kansas City Gen. Hosp.)

2. FULL NAME

Robert Pope
(a) Residence No. 920 Wyandotte St. Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 50 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) March 24 1897

7. AGE	YEARS	MONTHS	DAYS	IF LESS than day, hrs. or min.
	<u>59</u>	<u>0</u>	<u>12</u>	

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 _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Don't know

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT

Reverend Clerk
(Address) Kansas City Gen. Hosp.

15. FILED

4/8 30 M. M. Cronin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-6 1930

17. I HEREBY CERTIFY That I attended deceased from 3-16, 1930 to 4-6, 1930
that I last saw him alive on 4-6, 1930 and that death occurred, on the date stated above, at 10:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Larynx

H1A 4-9 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

18 DID AN OPERATION PRECEDE DEATH DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) P. O. Williams, M. D.

4-7 1930 (Address) Supr. R. S. 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 DATE OF BURIAL

Memorial Park 4/8 1930

20. UNDERTAKER F. O. Donnell ADDRESS 3256 Broadway

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.

