

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

Do not use this space.

16282

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Jawa Primary Registration District No. 1003  
City Kansas City (No. Kansas City Gen Hosp) St. Mo Ward 20 11

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

George Steel  
(a) Residence. No. 2811 Harrison St. 4 Ward. (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unknown</u>		
7. AGE	YEARS <u>81</u>	MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>none</u> (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) Penn  
10. NAME OF FATHER Wm Steel  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Penn  
12. MAIDEN NAME OF MOTHER unknown  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Penn

**14.**

INFORMANT Reverend Clerk  
(Address) Kansas City Gen Hosp

**15.**

FILED 3/25/30 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-10, 1930, to 5-23, 1930 that I last saw him alive on 5-23, 1930 and that death occurred, on the date stated above, at 5:30 P. M.

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

Hypertrophy of Prostate  
137  
107A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY Pneumonia (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Spec. Anal + Autopsy  
(Signed) P. C. Williams M. D.

5-23, 1930 (Address) Supr 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** DATE OF BURIAL

Woodland Cemetery 9/24/30

**20. UNDERTAKER** ADDRESS

W. M. East 1415 1/2 St

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

