

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

Do not use this space.

**19503**

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 1002  
 Township Yakaw Primary Registration District No. 1002 Registered No. 2439  
 City Kansas City (No. Kansas City Gen Hosp) St. Mo Ward

**2. FULL NAME**

Ely John E  
 (a) Residence. No. Jackson County Home Ward. (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 0 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** Divorced  
(write the word)

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** Mary Ely

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** August 7-1860

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
89 10 8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. none  
 (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)** New York

**10. NAME OF FATHER** no record  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** no record  
**12. MAIDEN NAME OF MOTHER** no record  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** no record

**14. INFORMANT** Deerua Clerk  
 (Address) K.C. General Hosp

**15. FILED** 9/6 1930 M. M. Casper REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** June 15, 1930

**17. I HEREBY CERTIFY, That I attended deceased from** June 13, 1930, to June 15, 1930  
 that I last saw him alive on June 15, 1930, and that death occurred, on the date stated above, at 7:50 P. m.

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

Hypertrophy of Prostate  
107A  
137  
 (duration) ..... yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)** Bronchopneumonia  
 (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED** at home  
 IF NOT AT PLACE OF DEATH

**DID AN OPERATION PRECEDE DEATH?** no DATE OF

**WAS THERE AN AUTOPSY?** yes

**WHAT TEST CONFIRMED DIAGNOSIS?** Autopsy  
 (Signed) P. E. Williams M. D.

6-16, 1930 (Address) Supt 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** Forest Hill **DATE OF BURIAL** 6/17 1930

**20. UNDERTAKER** Mrs. E. L. Forster **ADDRESS** R. E. Mo.

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.

