

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

Do not use this space.

19548

1. PLACE OF DEATH

County Jackson
Township Yean
City Kansas City

Registration District No. 399
Primary Registration District No. 1002

File No. 2548
Registered No. 2548 (Ward)

2. FULL NAME

(a) Residence. No. Helping Hand 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) Went Know

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Went Know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 06 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Went Know
(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) Went Know

10. NAME OF FATHER Went Know

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

12. MAIDEN NAME OF MOTHER Went Know

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

14. INFORMANT Reverend Clerk (Address) K.C. Gen. Hosp.

15. FILED of 19 30 M M. Crowe REGISTRAR Beav

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-17 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-16 1930 to 6-17 1930 that I last saw him live on 6-17 1930 and that death occurred, on the date stated above, at 4:35 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Hemorrhage
82A

CONTRIBUTORY (SECONDARY) 74044 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH. DATE OF WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Brain And Autopsy (Signed) P. G. Williams M. D. 6-18 1930 (Address) Sur T.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 Seeds. 6-20-30 19

20. UNDERTAKER ADDRESS O. V. Mast Kc 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.

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

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