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

Do not use this space.

22855

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kaw — Primary Registration District No. 1002 — Registered No. 2847

City Kansas City (No. Kansas City Gen Hosp St. Ward)

2. FULL NAME William Hathaway

(a) Residence. No. 302 Main St., 1 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	54	2	3	

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

37

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Mo

1

PARENTS

10. NAME OF FATHER Homer Hathaway

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

2

12. MAIDEN NAME OF MOTHER Annie Quinn

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

14. INFORMANT Record Clerk
(Address) K. C. General Hosp

15. FILED 7/11, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-10 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-3, 1930, to 7-10, 1930 that I last saw him alive on 7-10, 1930 and that death occurred, on the date stated above, at 11:40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A (Chronic)
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) P. E. Williams, M. D.
7-11, 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	DATE OF BURIAL
Miami Okla	July 11 1930

20. UNDERTAKER — ADDRESS
D W Newcome's Sons

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.