

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

Do not use this space.

23062

1. PLACE OF DEATH

County **Jackson**
Township **Kaw**
City **Kansas City**

Registration District No. **899**
Primary Registration District No. **1015**
(No. **St. Marys Hospital**)

File No. _____
Registered No. **3056**
St. _____ Ward)

2. FULL NAME William Bage Kron

(a) Residence. No. **1008 Bales** St. **12** 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 **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Divorced**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 12 1895**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 0 10

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

9. BIRTHPLACE (CITY OR TOWN) **Kansas City**
(STATE OR COUNTRY) **Kansas**

10. NAME OF FATHER **Aug Krom**

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

12. MAIDEN NAME OF MOTHER **Hessie Koaths**

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

14. INFORMANT **Arther Kron**
(Address) **1008 Bales**

15. FILED **7/24/30** **M. M. Crowe**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 22 1930**

17. I HEREBY CERTIFY, That I attended deceased from **July 15 1930**, to **July 22 1930**, that I last saw him alive on **July 22 1930**, and that death occurred, on the date stated above, at **8 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**acute sublethral
obstruction
12/13
1930** (duration) yrs. mos. ds. **2**
CONTRIBUTORY **Chronic Inflammation & Enlargement
of the Coronary & Aortic Valves**
(SECONDARY) (duration) yrs. mos. ds. **10**

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

DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **July 20-30**

WAS THERE AN AUTOPSY? **yes**
WHAT TEST CONFIRMED DIAGNOSIS? **Operative Autopsy**
(Signed) **J. H. Lewis**, M. D.

(Address) **Kansas City Mo**
*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 **Mount Washington** DATE OF BURIAL **7 25 19 30**

20. UNDERTAKER **W. H. Blackburn** ADDRESS **Keetty, 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.

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