

SEP 22 1930

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

Do not use this space.

25878

O.T.

1. PLACE OF DEATH

County Boone  
Township  
City Columbia (No. ....)

Registration District No. 73  
Primary Registration District No. 3006

File No. ....  
Registered No. 178  
St. .... Ward)

2. FULL NAME

Owen S. Kite Jr

(a) Residence, No. 209 North Ave 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male white single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or mln.

- 3 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home  
(b) General nature of industry, business, or establishment in which employed (or employer) -  
(c) Name of employer

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

10. NAME OF FATHER Owen S. Kite

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Boone Co Mo  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Helmath A. Kilit

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Boone Co Mo  
(STATE OR COUNTRY)

14. INFORMANT Owen S. Kite  
(Address) 209 North Ave

15. FILED Aug 30 1930 Beatrice Grubb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 29 1930

17. I HEREBY CERTIFY, That I attended deceased from 8/20/30 19... to 8/29/30 19... and that I last saw him alive on 8/29/30 at 3:30 P and that death occurred, on the date stated above, at... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Dysentery

CONTRIBUTORY (SECONDARY) 13/2 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) S. A. Woodford M. D.  
20 1930 (Address) Columbia 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 Smith Chapel DATE OF BURIAL Aug 30 1930

20. UNDERTAKER B. B. Baker ADDRESS Columbia

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

