

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

Do not use this space.

26655

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1002
 City Kansas City (No. 607 West 59th Street) St. _____ Ward _____

File No. _____
 Registered No. 3258

2. FULL NAME Webster Hutcheson

(a) Residence. No. 607 West 59th Street St. 8 Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katherine Hutcheson		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 24, 1899		
7. AGE	YEARS 31	MONTHS 6
	DAYS 12	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Druggist**
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer **Owner of Armour Pharmacy
 Armour Blvd & Troost**

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Illinois**

10. NAME OF FATHER **Alexander H. Hutcheson**

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

12. MAIDEN NAME OF MOTHER **Elizabeth White**

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

14. INFORMANT **Mrs. Anna Hutcheson**

(Address) **607 West 59th St**

15. FILED 8/11/30 M. M. Corrowe
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 6, 1930** 19

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Mitralism Heart
 730
 490 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) **Fatty Degeneration of Heart**
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
20. WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) Stanley M. Hall, M.D.
 8/11/30 (Address) Deputy Coroner

*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
8-3-30 19

Mt Moriah Cem

20. UNDERTAKER
R. V. Lindsey & Sons, Inc

ADDRESS
No City, 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.

