

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

Do not use this space.

26724

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Kans Primary Registration District No. 002  
 City Kansas City (No. 2628 Garfield) St. 4 Ward 4  
 File No. \_\_\_\_\_ Registered No. 3328  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME John D. Ewing  
 (a) Residence No. 2628 Garfield St. 4 Ward 4  
 (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*) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 - 1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>0</u>	<u>6</u>	

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

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

10. NAME OF FATHER Robert Ewing

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Sallie Pryor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) unknown

14. INFORMANT T. M. Hymore  
 (Address) 116 Brooklyn

15. FILED 8/11, 1930 M. M. Crowe  
 asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

I HEREBY CERTIFY, That I attended deceased from July 10th, 1930, to Aug 10, 1930 that I last saw h. a. alive on Aug 28, 1930, and that death occurred, on the date stated above, at 10:15 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Carcinoma of rectum  
468 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) 45 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

1. DID AN OPERATION PRECEDE DEATH? yes DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) James McWhorter, M. D.  
8/10 1930 (Address) 818 Rialto Bldg.

\*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 Liberty Mo. DATE OF BURIAL Aug 11 1930

20. UNDERTAKER Mrs C L Forster ADDRESS 918 Brooklyn

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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