

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

Do not use this space.

29986

1. PLACE OF DEATH

County Jackson
Township Grant
City Kansas City

Registration District No. 399

Primary Registration District No. 1002

File No. _____
Registered No. 3793 St. _____ Ward _____

2. FULL NAME

(a) Residence No. 917 E. 9th St., _____ 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-10-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 4 3

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Pikeville
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Robert Owen

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

12. MAIDEN NAME OF MOTHER Darcey Webb

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

14. INFORMANT Recard Beek
(Address) Kansas City Gen. Hosp.

15. FILED 9/15, 1930 M. W. Crowe
REGISTRAR Assr

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-13-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-3-, 1930, to 9-13-, 1930 that I last saw him alive on 9-13-, 1930, and that death occurred, on the date stated above, at 11:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis with
Uremia
131
1320 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Uremia
(duration) yrs. mos. da.

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) W. C. Gault, M. D.

9-13, 1930 (Address) K. C. General 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 Oakland Cemetery, Harrisonville, Mo. DATE OF BURIAL 9/14/30

20. UNDERTAKER Remmenburger Bros & Co ADDRESS Harrisonville

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

md

