

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

Do not use this space.

30055

1. PLACE OF DEATH

County Adair
Township Ross
City Kansas City (No. Kansas City General Hospital)

Registration District No. 1002
Primary Registration District No. 399

File No. 3001
Registered No. 3001 St. _____ Ward _____

2. FULL NAME

Wherrett - W. U.
(a) Residence. No. Adams Home St. - Wornall 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. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-21-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 3 18

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Recy (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer) News-Graphic Press
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Evansville
(STATE OR COUNTRY) Indiana

10. NAME OF FATHER Isaac W. Wherrett

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Indiana
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Cleanor Dutton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indiana
(STATE OR COUNTRY) _____

14. INFORMANT Recy Wherrett
(Address) Kansas City Gen Hosp

15. FILED 9/21, 1930 M. M. Crow
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-20 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-17, 1930, to 9-20, 1930
that I last saw h. a. l. alive on 9-20, 1930, and that death occurred, on the date stated above, at 10:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
131
93C (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
Chronic Nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) P. E. Williams, M. D.
9-21, 1930 (Address) Sup't. K. B. Emory 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 Grave, Kansas DATE OF BURIAL 9/22, 1930

20. UNDERTAKER Newcomer's Co ADDRESS 2111 E 9th

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.

