

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

Do not use this space.

32916

1. PLACE OF DEATH

County Jackson
Township Kear
City Kansas City

Registration District No. 395
Primary Registration District No. 1002
(No. Kansas City Gen. Hosp.) St. _____ Ward _____

File No. _____
Registered No. 4524
St. _____ Ward _____

2. FULL NAME

William Kingen
(a) Residence. No. 1415 Harrison 2 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 22 1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>45</u>	<u>5</u>	<u>19</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Omaha
(STATE OR COUNTRY) Nebraska

10. NAME OF FATHER Alman P. Kingen

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

12. MAIDEN NAME OF MOTHER Mary L. Jones

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

14. INFORMANT Reverend Clerk
(Address) K.C. General Hosp.

15. FILED 10/12 1930 M. M. Kerowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11 1930

17. I HEREBY CERTIFY, That I attended deceased from 10-9 1930 to 10-11 1930 that I last saw her alive on 10-11 1930, and that death occurred, on the date stated above, at 2:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ruptured Duodenal ulcer
117B
129

CONTRIBUTORY (SECONDARY) Peritonitis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 11173/1w
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS Clin. Find + Autopsy
(Signed) P. E. Williams M. D.

10-11 1930 (Address) Subst K.C. Gen. 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 St. Marys Cemetery DATE OF BURIAL Oct. 13 1930

20. UNDERTAKER John J. Sheehan ADDRESS Kansas City, Mo.

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.

