

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

Do not use this space.

36232

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Beau Primary Registration District No. 1002
City Kansas City (No. K.C. Gene Hosp) St. _____ Ward _____

File No. _____
Registered No. 4638
St. _____ Ward _____

2. FULL NAME

Sam Harrison
(a) Residence. No. 2415 McClary St. 3 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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug. 27-1899</u>		
7. AGE YEARS <u>51</u>	MONTHS <u>2</u>	DAYS <u>17</u>
If LESS than 1 day, _____ hrs. or _____ min.		

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

PARENTS	10. NAME OF FATHER <u>Andrew Harrison</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill</u>
	12. MAIDEN NAME OF MOTHER <u>Mary Cowan</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Pa</u>

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

15. FILED 11/16 3 20 M.M. Brown
REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-14 1930
17. I HEREBY CERTIFY, That I attended deceased from 11-1 1930 to 11-14 1930
that I last saw him alive on 11-14 1930 and that death occurred, on the date stated above, at 1:05 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterial Hypertension
102
CONTRIBUTORY (SECONDARY) Acute Dilatation of the Heart
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Clinical Findings
(Signed) P. B. Williams, M. D.
11-15 . 19 30 (Address) Subt K.C. Gene 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 Forest Hill DATE OF BURIAL 11-17 30

20. UNDERTAKER O.V. Marx ADDRESS 915 E 15

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.

