

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

Do not use this space.

36241

1. PLACE OF DEATH

County Jackson
Township Kansas City
City K.C. Mo

Registration District No. 399
Primary Registration District No. 2002
(No. General Hospital # 2)

File No. _____
Registered No. 4647
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2120 Charlotte 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. 13 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 Negro 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) Jan 24 - 1912

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 9 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jefferson City Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Felix Gill

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jefferson City Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jefferson City Mo.
(STATE OR COUNTRY)

14. INFORMANT Record Clerk
(Address) General Hosp. no 2

15. FILED 11/17/30 M. M. Crone
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 12, 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 11, 1930, that I last saw him alive on 11/17/30, 1930, and that death occurred, on the date stated above, at 11/12/30 1:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23 1/2 (duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (SECONDARY) 31 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 2120 Char. St.

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical - x-ray
(Signed) D. M. Miller M. D.

11/13, 1930 (Address) Hospital # 2

*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 Blue Ridge Lawn DATE OF BURIAL 11-17-30

20. UNDERTAKER Fitzger & Greenbaum ADDRESS KC. Mo.

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.

STATE DEPARTMENT WITH REGARDING THIS IS A PERMANENT RECORD

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