

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

Do not use this space.

1629 462

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City (No. K.C. General Hosp.)

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

2. FULL NAME

Otto Christer

(a) Residence. No. 515 E. Missouri Ave., St. 1 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) Not known

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 60 - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(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) Not known

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Record Clerk

(Address) K. C. General Hosp.

15. FILED 1/31 1931 M. M. Crowl REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Pneumonia
1945
107A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fract. of leg.
No history as to how injury was received
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NO. AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
HAD THERE BEEN STOPS _____
WHAT TEST CONFIRMED DIAGNOSIS Autopsy
(Signed) Stanley M. Drake M. D.
1/29 1931 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or if 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 Floral Hills Cem. DATE OF BURIAL 1-31-31 19

20. UNDERTAKER J.P. Louis Funeral Home ADDRESS City

K. 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.

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