

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

Do not use this space.

5435
519

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 2108
Primary Registration District No. 1342
(No. 5700 Tracy)

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

2. FULL NAME James W. Victor

(a) Residence. No. 5700 Tracy St. 15 Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 43 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 Mrs. Mary Victor

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 1, 1842

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
88 10 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Carpenter 24
(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) Mo. 1

PARENTS

10. NAME OF FATHER Thomas Victor

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14.

INFORMANT Samuel R. Victor
(Address) 106 N. Phelps

15.

FILED 7/3 1931 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 3rd. 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1931, to Feb. 3 1931, and that I last saw him alive on Feb. 3 1931, and that death occurred, on the date stated above, at 9:50 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitro - regurgitation
920 (duration) 5 yrs. 10 mos. 3 ds.
CONTRIBUTORY (SECONDARY) Chronic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF None

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Geo. W. Graham, M. D.
Feb 3 1931 (Address) 205 Argyle Bldg

*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 Mt. Moriah Cemetery DATE OF BURIAL 2/5/31 19
20. UNDERTAKER Freeman Mortuary Kansas City, Mo ADDRESS

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.

Dr. Graham
Argyle Bldg
104

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
Towship..... Primary Registration District No..... Registered No. 519
City..... (No. 5700) Tracy St. Ward)

2. FULL NAME

James W Victor
(a) Residence No. 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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 9/3 19 31 M. M. Crowe REGISTRAR
ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/3 19 51

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Metical Resurgitation
..... (duration) 5 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Pneumonia
Lobar (duration) yrs. mos. 3 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) James W. Johnson M. D.
..... (Address) 205 Myrtle K.C. Mo

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

3-5435