

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

Do not use this space.

10289

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas

399

Registration District No. \_\_\_\_\_  
Primary Registration District No. 1002  
General Hospital #2

File No. \_\_\_\_\_  
Registered No. 1737  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Henry M. Gue  
(a) Residence. No. 381 Forest Ave. St. 1 Ward. \_\_\_\_\_

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX. Male  
4. COLOR OR RACE Colored  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-29 1931

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

17. I HEREBY CERTIFY, That I attended deceased from 3 11 11, 1931, to 3-29 1931 that I last saw him alive on 3-29 1931, and that death occurred, on the date stated above, at 11:30 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 27 1897

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Tuberculosis  
23A

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
33 6 2

(duration) \_\_\_\_\_ yrs. mos. da.

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 \_\_\_\_\_

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) \_\_\_\_\_ yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) Tenn.  
(STATE OR COUNTRY) \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED  
NOT AT PLACE OF DEATH.

10. NAME OF FATHER Joe M. Gue

0 DID AN OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kirksville MO.

12. MAIDEN NAME OF MOTHER Genie Zuber  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miss.  
(STATE OR COUNTRY) \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS cleared  
(Signed) D. M. Miller M.D.  
3/30, 1931 (Address) General Hospital #2

14. INFORMANT Edward O. Clark  
(Address) General 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.

15. FILED 4/13 31 M. M. Capron  
REGISTRAR anon

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kirksville MO. DATE OF BURIAL 4/10 1931  
20. UNDERTAKER West Appler Jones ADDRESS K.C. MO

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

