

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Kaw Primary Registration District No. 1002

City Kansas City (No. General Hosp # 2) St. _____ (Ward) _____

17920
File No. _____
Registered No. 2058
St. _____ (Ward) _____

2. FULL NAME

(a) Residence. No. 1627 E. 11th St. 2 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 74 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 27, 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>74</u>	<u>6</u>	<u>5</u>		

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) (STATE OR COUNTRY) no

10. NAME OF FATHER John Washington

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no

12. MAIDEN NAME OF MOTHER Eliza Anthony

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no

14. INFORMANT Record Clerk
(Address) Gen Hosp # 2

15. FILED 94 1931 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-2-1931

17. I HEREBY CERTIFY, That I attended deceased from 1-20- 1931, to 5-2- 1931, that I last saw decd. alive on 5-2- 1931, and that death occurred, on the date stated above, at 10:40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
57A
myocardial failure

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) myocardial insufficiency
the arthritis deformans (duration) _____ yrs. _____ mos. _____ ds.

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

DID OPERATION PRECEDE DEATH? no DATE OF _____

(WAS THERE AN AUTOPSY?) yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy & Clinical

(Signed) W. M. Miller M. D.
573 .1931 (Address) Gen Hosp # 2

*State the DISEASES 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 Highland DATE OF BURIAL 5/4 1931

20. UNDERTAKER Hatkins Bros. ADDRESS 1729 Lydia

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

