

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

Do not use this space.

18224

1. PLACE OF DEATH

County Jackson
Township Kaw
City K.C. Mo

Registration District No. 309
Primary Registration District No. 108
(No. Mercy Hospital)

File No. _____
Registered No. 2266
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 331 Wentworth St., _____ Ward. Lexington, Mo
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 19, 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
5 7 8

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) none
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Robert Hanna

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

12. MAIDEN NAME OF MOTHER Birdie Tudders

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

14. INFORMANT (Address) Robert Hanna
Lexington, Mo.

15. FILED May 22, 1931 W. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/27/31 19
17. _____

I HEREBY CERTIFY, That I attended deceased from 5/24/31, 1931, to 5/27/31, 1931, that I last saw him alive on 5/27/31, 1931, and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
3
4 Pulmonary Wc
23

CONTRIBUTORY (SECONDARY) Wc meningitis - duration?
Bilateral White Media
Bilateral mastoiditis 2 wks.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Exam - Lab - autopsy
(Signed) W. M. Howard, M. D.

5/27/1931 (Address) Mercy Hosp
*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 Lexington, Mo. DATE OF BURIAL 5-27 1931

20. UNDERTAKER Mrs. G. L. Forster ADDRESS K.C. Mo

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.

