

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

Do not use this space.

399

29648

PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 1002
Primary Registration District No. General Hospital

File No. 3572
Registered No. 3572
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 216 N. Elmwood St. Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 10 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 Leavie West

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 29 - 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
48 10 7

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Shoe repair shop

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Jersey

13. NAME Frank West

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record

15. MAIDEN NAME Hellie Fenney

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT (ADDRESS) Record Clerk K. C. General Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Sept 4 - 1933

19. UNDERTAKER (ADDRESS) Mrs. C. T. Forster 918 Pennsylvania ave.

20. FILED 7-8 1933 M. M. Crowe Registrar

3. MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-6 1933

22. I HEREBY CERTIFY, That I attended deceased from 8-30 1933 to 9-6 1933

I last saw him alive on 9-3 1933 Death is said to have occurred on the date stated above, at 11:50 a.m.

The principal cause of death and related causes of importance were as follows:

Peritonitis following intestinal obstruction

Other contributory causes of importance: 122 B 129

Name of operation Exploratory Laparotomy date of 8-30-33
What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) J. H. Bennett, Supp. M. D.
(Address) K. C. General Hosp

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.

OCT 20 1933

MOTHER FATHER 2 31 40

