

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

Do not use this space.

14879

1924

**1. PLACE OF DEATH**

County Jackson  
Township Paul  
City Hampton City (No. 555)

Registration District No. ....  
Primary Registration District No. ....

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 555 St. Lawrence 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 Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 22, 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>60</u>	<u>5</u>	<u>2</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work at home  
(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) Ill

10. NAME OF FATHER J. M. Nutt

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

12. MAIDEN NAME OF MOTHER Katherine Lillington

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

14. INFORMANT J. L. Organ (Address) 27 Linwood Cr

15. FILED 4/24-29 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 24 1924

17. I HEREBY CERTIFY, That I attended deceased from Apr 14 1924 to Apr 24 1924  
that I last saw h. er alive on Apr 23 1924 and that death occurred, on the date stated above, at 2:40 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma of Stomach & gall bladder  
4-6-12 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 44 (duration) yrs. mos. 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) Albert Hansen M.D. (Address) 236 Brotherhood Alley & C. Han

\*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 Clinton Mo DATE OF BURIAL 4/26 1924

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K 6 Mo

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.

WHITE (PARENT) WITH UNFADING INK—THIS IS A PERMANENT RECORD

Harms.

Brookwood

Box 0088: