

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

Do not use this space.

11652

1. PLACE OF DEATH

County Jackson Registration District No. 389
 Township Jackson Primary Registration District No. 103
 City Kansas City (No. K.C. General Hosp) Registered No. 1443
 St. _____ Ward _____

2. FULL NAME

Glen West
 (a) Residence No. Evans Home Ward _____
 (Usual place of abode) _____
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Unknown</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE YEARS	MONTHS	DAYS
	<u>4</u>	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer <u>Chief</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
10. NAME OF FATHER <u>"</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>"</u>		
12. MAIDEN NAME OF MOTHER <u>"</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>"</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-3 1927

17. I HEREBY CERTIFY That I attended deceased from 3-26 1927 to 4-3 1927 that I last saw him alive on 4-3 1927 and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
Intentional Influenza
 (duration) yrs. mos. ds. 11A 11A

CONTRIBUTORY (SECONDARY)
Intentional Influenza
 (duration) yrs. mos. ds. 11A 11A

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? Chem. Findings & Autopsy
 (Signed) P. O. Williams M. D.
4-4, 1927 (Address) Subt. K.C. Genl Hosp

14. INFORMANT Re word Clerk
 (Address) K.C. General Hosp

15. FILED 4/5 27 Dr. M. Crowe
Acce REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leeds DATE OF BURIAL 4-5 1927

20. UNDERTAKER O. J. Mast ADDRESS City

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.

