

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

Do not use this space.

21655

1. PLACE OF DEATH

County Jackson
Township Kaw
City J.C. Mo.

Registration District No. 399
Primary Registration District No. 1002
No. 223-E-35th st

File No. _____
Registered No. 3002
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 223-E-35th 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. 1 mos. 2 How long in U.S., if of foreign birth? yrs. _____ mos. _____ da. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX He 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 William F. Files

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 23-1858

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>8</u>	<u>8</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer 53E

9. BIRTHPLACE (CITY OR TOWN) Sherman
(STATE OR COUNTRY) Texas

10. NAME OF FATHER Adam Hoop

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

12. MAIDEN NAME OF MOTHER Mary Files

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

14. INFORMANT Clarence Files
(Address) 223-E-35th

15. FILED 8/1 27 M.M. Brown
REGISTRAR asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31 1927

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1927, to July 31, 1927, and that I last saw him alive on July 31, 1927, and that death occurred, on the date stated above, at 2-40 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of mesentery

CONTRIBUTORY (SECONDARY) Toxaemia of cancer
(duration) _____ yrs. _____ mos. _____ da.

18. WHEN WAS DISEASE CONTRACTED 45
IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Fred Hatch, M. D.
8/1, 1927 (Address) 1015 Chambers Bldg

*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 Savannah Mo. DATE OF BURIAL Aug 3 1927

20. UNDERTAKER Mrs. C. L. Foster ADDRESS J.C. 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.

