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

Do not use this space.

24278

1. PLACE OF DEATH
County: Jackson — Registration District No.: 399 — File No.:
Township: Kan — Primary Registration District No.: 1002 — Registered No.: 3000
City: Kansas City (No. K.C. Gen'l Hosp. St. Ward)

2. FULL NAME: Maxwell James
(a) Residence. No. 408 E. 9th 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Unknown

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dont Knew.

7. AGE: Years 38 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Helper Journ post
(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): Ireland

PARENTS
10. NAME OF FATHER: Dont Knew
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Knew
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: Record Clerk
(Address) K.C. Gen'l Hosp.

15. FILED: 8/5, 1927 M. M. Crane asst REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-4 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-10, 1927, to 8-4, 1927, that I last saw him alive on 8-4, 1927, and that death occurred, on the date stated above, at 5:25 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial insufficiency.
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(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? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings
(Signed) George C. Lee, M. D
8-4, 1927 (Address) Asst Supt K.C. Gen'l 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: Maple Hill — DATE OF BURIAL: 8/6 1927
20. UNDERTAKER: C. A. Mast — ADDRESS: 1918 East 15

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.

PERMANENT RECORD