

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

Do not use this space.

24538

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kan Primary Registration District No. 1002
 City Kansas City (No. 722 General Hosp) St. _____ Ward _____

File No. _____
 Registered No. 2377
 St. _____ Ward _____

2. FULL NAME

Dyck, George
 (a) Residence. No. 406 1/2 Main 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>about 35</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Porter
 (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) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Record Clerk
 (Address) General Hospital

15. FILED 8/28 27 M. M. Crowe REGISTRAR
wee

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-28 1927

17. I HEREBY CERTIFY, That I attended deceased from 8-26, 1927 to 8-28, 1927 that I last saw him alive on 8-28, 1927 and that death occurred, on the date stated above, at 2:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
73A Pneumonia
73D Myocardial Insufficiency
Cardiac Failure
 (duration) yrs. _____ mos. 2 ds.

CONTRIBUTORY (SECONDARY) Pneumonia, Broncho
 (duration) yrs. _____ mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) George C. Lee, M. D.

8-28 1927 (Address) Cust Supt 722 Genl 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 St. Maryslem DATE OF BURIAL 8-30 1927

20. UNDERTAKER O. V. Mast ADDRESS 1915 E. 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.

NON-PAYING INK—THIS IS A PERMANENT RECORD

