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

U.S.Veterans Bureau Hospital

Do not use this space.

33442

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 4212
Township Kansas City Mo — Primary Registration District No. 1002 — Registered No.
City ..... (No. U. S. Veterans Hospital St. ..... Ward)

2. FULL NAME Will Mier
(a) Residence. No. / St., ... Ward. Atchison Kan.
(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. 16 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 27 1897

7. AGE: Years 30 — Months 5 — Days 10 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: not given

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lancaster Kan.

PARENTS
10. NAME OF FATHER: W.M.Mier.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not given.
12. MAIDEN NAME OF MOTHER: Not know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not known

14. INFORMANT: Hospital records.
(Address) K. C. Mo

15. FILED 11/6, 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 6th. 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 21st.1927, 19..., to Nov.6.1927, 19..., that I last saw him alive on Nov 5th.1927, 19..., and that death occurred, on the date stated above, at 1 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cholecystitis
125 B
127 B
Unknown (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY): Abcess of liver,
Cholangitis (duration) yrs. mos. ds.
2 months

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Unknown
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Sept 27.19
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Operation and laboratory
(Signed) [signature], M. D
11/6, 1927 (Address) E.J.Rose
Medical Officer in Charge

*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: Atchison Kansas
DATE OF BURIAL: 11/6 1927

20. UNDERTAKER: Westport Undertakers
ADDRESS: K.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.

...THIS IS A PERMANENT RECORD