

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

Do not use this space.

37083

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Jean Primary Registration District No. 1002 Registered No. _____
 City Kansas City (No. Kansas City Genie Hosp.) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Almo Hotel 11th & Bent 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>4-8-1854</u>		
7. AGE	YEARS <u>73</u>	MONTHS <u>8</u>
	DAYS <u>18</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Druggist</u> (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) Michigan

PARENTS	10. NAME OF FATHER <u>Darius Sessions</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Michigan</u>
	12. MAIDEN NAME OF MOTHER <u>Mary Fisher</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Kentucky</u>

14. INFORMANT Mrs. M. F. Lippas
 (Address) 2509 Benton av.

15. FILED 12/27, 1927 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-26-1927

17. I HEREBY CERTIFY, That I attended deceased from 12-13-1927 to 12-26-1927 that I last saw him alive on 12-26-1927, and that death occurred, on the date stated above, at 7:10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
General Arteriosclerosis
Anteriodorsal Obliterating Endarteritis
996 (duration) yrs. mos. ds.
 CONTRIBUTORY 97 (SECONDARY) 970 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

21. WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) George C. Fee M. D.
12/27, 1927 (Address) General Hosp. 11th & Bent St.

*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 <u>Mt. Washington</u>	DATE OF BURIAL <u>Dec 27 1927</u>
20. UNDERTAKER <u>Mrs. C. L. Foster</u>	ADDRESS <u>K.C. Mo.</u>

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.

