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

Do not use this space.

8791

399

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City Mo (No. 1 2514 Agnes St. Ward)
Registration District No. 100
Primary Registration District No. 1 2514 Agnes
*File No. ...
Registered No. ...

2. FULL NAME Charles William Rackliff
(a) Residence. No. 2514 Agnes 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 1865

7. AGE: Years 72 | Months 8 | Days 18 | If LESS than 1 day, ... hrs. or ... min.

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

9. BIRTHPLACE (CITY OR TOWN) Belmont
(STATE OR COUNTRY) N.Y.

PARENTS
10. NAME OF FATHER William H Rackliff
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ...
(STATE OR COUNTRY) Main
12. MAIDEN NAME OF MOTHER E. Mapes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ...
(STATE OR COUNTRY) N.H.

14. INFORMANT Sue Rackliff
(Address) 2514 Agnes

15. FILED 3/2 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-2 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1928, to March 1, 1928 that I last saw him alive on March 1, 1928, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Endocarditis
122 A
122 B
129 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Obstruction, Bowels & Peritonitis
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No. DATE OF ...
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Overwritten
(Signed) Robt. M. Smith, M. D
3/2, 1928 (Address) 505 Emel Ave Tempe

*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: Carthage Mo
DATE OF BURIAL: 3/2 1928

20. UNDERTAKER: O V Mast
ADDRESS: 1925

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township — Primary Registration District No. 1002 — Registered No. 949
City K. City (No. ..... St. ..... Ward)

2. FULL NAME Charles William Rackley
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

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

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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

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

14. INFORMANT
(Address)

15. FILED 3/2 1928 M. M. Crouch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 2 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Endocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY Obstruction, Chronic Bowels
SECONDARY Operation for Double Hernia
Big Ancrit (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Lexington.
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Roy. M. Smith M. D
3/15 1928 (Address) 508 Gunther 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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

1861

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