

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

Do not use this space.

9088

1. PLACE OF DEATH

County..... Jackson Registration District No. 399 File No.
 Township..... Kansas City, Mo. Primary Registration District No. 100 Registered No. 265
 City..... Old City Hospital St. 1 Ward

2. FULL NAME

(a) Residence. No. 2015 Brooklyn St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 21 1904

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>23</u>	<u>10</u>	<u>28</u>	

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

10. NAME OF FATHER Love Greer

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

12. MAIDEN NAME OF MOTHER Elyzabeth Greer

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

14. INFORMANT Patient prior to death
 (Address) Casey City, 2015 Brooklyn

15. FILED 3/21, 1928 J. M. Craibe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-19 1928
 17. I HEREBY CERTIFY, That I attended deceased from 3-10, 1928, to 3-19, 1928 that I last saw him alive on 3-19, 1928 and that death occurred, on the date stated above, at 1:15 pm

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis far advanced

CONTRIBUTORS (SECONDARY) None
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.
 WHAT TEST CONFIRMED DIAGNOSIS? Percussion & smears
 (Signed) H. M. Smith, M. D.
3/20, 1928 (Address) Old City Hospital, KC.

*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 Blue Ridge Lawn DATE OF BURIAL 3/22, 1928

20. UNDERTAKER Hatkins Bros ADDRESS 1729 Lydia

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

