

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

Do not use this space.

30501

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Leau Primary Registration District No. _____
 City Kansas City (No. Kansas City Genl Hosp) St. _____ Ward _____

File No. _____
 Registered No. 30501
 St. _____ Ward _____

2. FULL NAME

Name Dobson Alex
 (a) Residence No. 547 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 <u>M</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 16 - 1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, — hrs. or — min.
	<u>50</u>		<u>24</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 1948 Laborer 1929
 (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) Germany

10. NAME OF FATHER Wm Dobson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Reverend Clerk (Address) K. C. Genl Hosp.

15. FILED 9/11, 1928 M. M. Crowe REGISTRAR
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3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-10 1928

17. I HEREBY CERTIFY That I attended deceased from 9-5, 1928 to 9-10, 1928 that I last saw him alive on 9-10, 1928, and that death occurred, on the date stated above, at MIOD a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Perforation of the descending colon by foreign body
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Peritonitis (SECONDARY)
 (duration) _____ yrs. _____ mos. _____ ds.

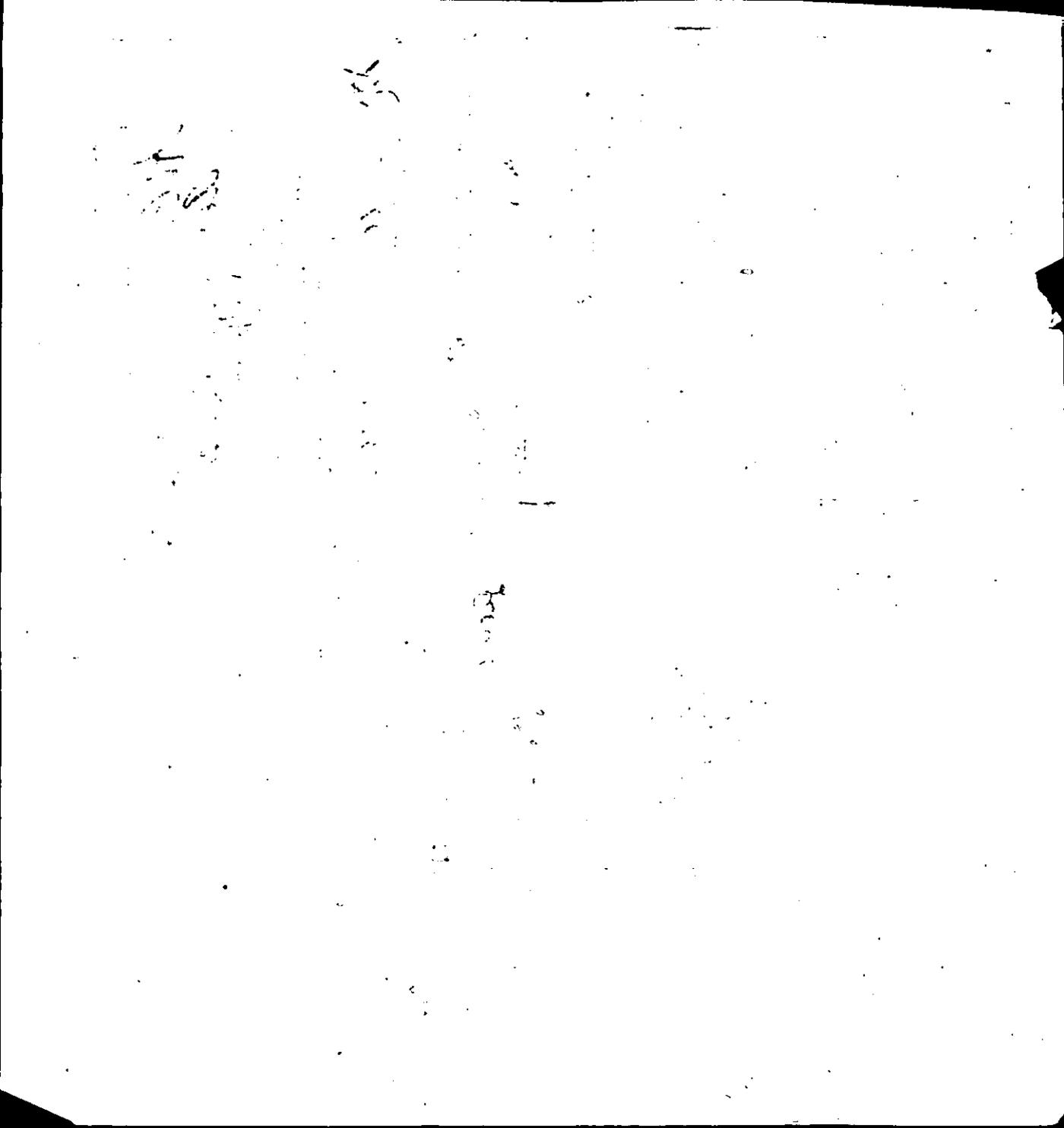
18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) John D. King G., M. D.
9-10, 1928 (Address) Asst Supt K.C. 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 Seeds. DATE OF BURIAL 9-11 1928

20. UNDERTAKER O. U. Mack ADDRESS Kans. City Mo



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ALL INFORMATION REQUESTED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 399 File No.....
 Township K. City Primary Registration District No. 1002 Registered No. 3752
 City K. City (No.) St. Ward

2. FULL NAME Alley Dobson

(a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. 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)

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 9/11 28 M.M. Crowe REGISTRAR
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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-10-1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Perforation of the descending colon by foreign body introduced through rectum
accidental (duration) yrs. mos. da.

CONTRIBUTORY Peritonitis (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF BIRTH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

H. B.

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