

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

Do not use this space.

14894

1. PLACE OF DEATH

Country Jackson Registration District No. 399

Township Raw Primary Registration District No. 1092

City, Village, or Hamlet Kansas City (No. 1021 West 7th)

File No. _____

Registered No. 1939

St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1021 St. 17th St. 4 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 Fe 4. COLOR OR RACE Colored 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) Aug. 23, 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
28 | 8 | 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
(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) Oklahoma

PARENTS

10. NAME OF FATHER J. M. Whitmire

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

12. MAIDEN NAME OF MOTHER Mae Adair

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

14.

INFORMANT Lewis Adair
(Address) 2021 St. 17th

15.

FILED 4/26, 1929 M. M. Conner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/25 1929

17. I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 21, 1929, that I last saw him alive on 21 April 1929, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis
Cerebral hemorrhage
Hypertension - 6 months
1115 (duration) yrs. mos. 14 ds.
CONTRIBUTORY Hypostatic Pneumonia
(SECONDARY) (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Don Carlos Peste, M. D.

4/25, 1929 (Address) 2116 1/2 W 24th - K.S.K.

*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 _____

Coffeyville Laun 4/25 1929

20. UNDERTAKER _____ ADDRESS _____

Hathins Buss 1729 Lydia

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.

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