

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

Do not use this space **27820**

~~3512~~  
~~3512~~  
~~3512~~  
**3512**

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Kaw Primary Registration District No. 1002  
City Kansas City (No. Kansas City Genl Hosp St. \_\_\_\_\_ Ward)

**2. FULL NAME** John Byroad

(a) Residence. No. 1701 Charlotte St. 3 Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-14 1929

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

17. I HEREBY CERTIFY, That I attended deceased from 8-10 1929 to 8-14 1929 that I last saw him alive on 8-14 1929 and that death occurred, on the date stated above, at 8:40 P. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2 - 1866

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>63</u>	<u>6</u>	<u>12</u>	

Mesenteric Thrombosis with gangrene of gut  
7/23/29

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

78 B (duration) yrs. mos. ds.  
10 7/29  
CONTRIBUTORY (SECONDARY) Hypertatic Broncho-pneumonia (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

18. WHERE WAS DISEASE CONTRACTED

10. NAME OF FATHER Ruben Byroad

IF NOT AT PLACE OF DEATH \_\_\_\_\_

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Margaret Smith

WAS THERE AN AUTOPSY? yes

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

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) P. E. Wheelers M. D.

14. INFORMANT Rena Clark  
(Address) K. C. Genl Hosp

15. FILED 8/16 1929 M. M. Crowe REGISTRAR  
asst.

\*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.

15. FILED 8/16 1929 M. M. Crowe REGISTRAR  
asst.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leeds DATE OF BURIAL 8-20 1929  
20. UNDERTAKER D. V. Mart ADDRESS \_\_\_\_\_

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

237  
2

N. B.—Every item of information should be carefully checked. AGE should be stated in years, months and days.

