

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

By and use the same.
33816
4268

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. General Hospital 1002

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

2. FULL NAME STOUT Herman B.

(a) Residence. No. 2708 Holmes 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 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 Christine Stout

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 11 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
37 11 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Landscape Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Benjamin Stout

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Christine Stout
(Address) 2708 Holmes

15. FILED 10/15/29 M. M. Crowe
REGISTRAR asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-13 1929

17. Deputy Coroner
I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, and 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:

Accidental Broken Neck
18 to 19 (duration) yrs. mos. ds.
19413

CONTRIBUTORY (SECONDARY) Yes from head while working (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1865
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS fracture of spine
(Signed) Stanley M. Hall, M. D.

10/15, 1929 (Address) Deputy Coroner

*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 Forest Hill DATE OF BURIAL Oct. 16 1929

20. UNDERTAKER Melody M. Kelly ADDRESS Kansas City Missouri
of funeral Home Inc.

K. B.—Every item of information should be carefully supplied. PHYSICIANS should be particularly careful. Cause of DEATH in plain terms, so that it may be properly classified. Extent of OCCUPATION is very important.

MENT RECORD

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PARENTS

36-1-1-2-31

**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.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1002

Registered No. 4268

City St. City (No.)

St. Ward)

2. FULL NAME

(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. 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) Nov 11 - 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
37 11 2

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 10/15, 1929 M.M. Brown REGISTRAR
Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1929

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:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

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

SUPPLEMENTARY

S-33816