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

Do not use this space.

13749

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City Kansas (No. City Hospital St. ..... Ward)

File No.....

Registered No. 4098

2. FULL NAME Ben O'Hanno

(a) Residence. No. 3616 N Montgall Ward. 16917

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....

(STATE OR COUNTRY) Tennessee

PARENTS

10. NAME OF FATHER Geo Harris

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Tennessee

12. MAIDEN NAME OF MOTHER Minnie Waters

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....

(STATE OR COUNTRY) Tennessee

14. INFORMANT ~~Hospital Informant~~ E R Bean

(Address) City Hospital

15. FILED APR 30 1927 Mark Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29 1927

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1927, to April 29, 1927, that I last saw h[illegible] alive on April 29, 1927 and that death occurred, on the date stated above, at 7:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ca. of Tongue Cancer

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

(duration) ..... yrs. ..... mos. ..... ds.

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) D H Lains, M. D

4/30, 1927 (Address) City Hospital

*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
Nashville Tennessee	5/1/27
20. UNDERTAKER	**ADDRESS**
A Kron L & M Co.	2707 W Grand Blvd