

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

33235

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. _____
 Township Maize Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. 4507 to 272) St. _____ Ward _____

2. FULL NAME

Virginia Mae DeFraties
 (a) Residence No. 4507 to 272 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18 1916

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
9 7 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Girl
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Denver
 (STATE OR COUNTRY) Colorado

10. NAME OF FATHER Wm DeFraties

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

12. MAIDEN NAME OF MOTHER May DeFraties

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

14. INFORMANT Wm DeFraties
 (Address) 4507 to 272

15. FILED 11-23 1919 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 21 1919

17. I HEREBY CERTIFY, That I attended deceased from 10/21, 1919, to 11/21, 1919, that I last saw him alive on 11/21, 1919, and that death occurred, on the date stated above, at 11-30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

10/21 - 11/21
11-30 a.m.
01 (duration) yrs. mos. ds. 10

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) _____, M. D.

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL Elwood DATE OF BURIAL 11-24 1919

20. UNDERTAKER Mrs C. L. Forster ADDRESS 110 E. Mo.

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.

MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

