

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

Do not use this space.

5120

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. Old City Loop)

Registration District No. 399
Primary Registration District No. 100

File No. _____
Registered No. 819
St. _____ Ward _____

2. FULL NAME

Marcelle Alexander
(a) Residence No. 2612 Montgall St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Colored

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)

Feb. 12 - 1926

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, _____ hrs. or _____ min.

1

13

8. OCCUPATION OF DECEASED

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

Iron

(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)

Miss

10. NAME OF FATHER

James Alexander

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

12. MAIDEN NAME OF MOTHER

Selma Young

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14.

INFORMANT James Alexander
(Address) 2501 N 75th St K.C.K.

15.

FILED 25 27th St. Crowe
REGISTRAR Asst

MEDICAL CERTIFICATE OF DEATH

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

2 - 25 - 1927

17.

I HEREBY CERTIFY, That I attended deceased from 2-22-, 1927, to 2-25-, 1927, that I last saw him alive on 2-25-, 1927, and that death occurred, on the date stated above, at 2:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A

Bronchopneumonia
1000
CONTRIBUTORY (SECONDARY) Rachitis (Rickets)
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical + Laboratory
(Signed) H. M. Smith, M. D.

2-25 - , 1927 (Address) Old City Hospital.

*State the DISEASE CAUSING DEATH, or in death 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

West Lawn Feb. 26 1927

20. UNDERTAKER

ADDRESS

K E Emb Cas Co 440 State

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

